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ILLINOIS DEPARTMENT OF PUBLIC AID
NOTICE OF PROPOSED AMENDMENTS TO THE RULE ON REGISTRATION/PARTICIPATION REQUIREMENTS

IDPA Rule 3.31 prescribes the conditions under which applicants and recipients must register for and participate in programs of employment and training for employment in order to be eligible for public aid.

Pursuant to Chapter 23, Section 12-13, Illinois Revised Statutes, the Department proposes to amend Rule 3.31. Authority for Rule 3.31 is established by Chapter 23, Section 4-1.8, 4-1.9, 6-1.4, 6-1.5, 9-5, 9-6, and 11-20, Illinois Revised Statutes. The principal amendment adds to the Rule a provision that AFDC applicants and recipients who are required to register for programs of employment or training for employment must provide the Department with verification of the registration as a condition of eligibility for AFDC. A paragraph concerning the AFDC eligibility of dependent children age 18 through 20 has been deleted as redundant because IDPA Rule 3.23 describes the eligibility conditions for this group. Additionally, the term "Illinois State Employment Service" has been changed to "Job Service in Illinois" or "Job Service" whereever it appears in the Rule, and several typographical errors have been corrected.

Within 14 days of the date of publication of this notice, any interested person may request the opportunity to submit comments, data, views or arguments regarding the proposed amendments. The request and submittals must be in writing and should be addressed to Mary Ann Langston, Assistant, Policy and Planning Administrator, Illinois Department of Public Aid, 316 South Second Street, Springfield, Illinois 62762. The Department will consider all written submittals made pursuant to such requests if the submittals are received within 35 days of the date of publication of this notice.

A complete text of the proposed Rule follows, which indicates the amended portions:

RULE 3.31 REGISTRATION/PARTICIPATION REQUIREMENTS

AABD

Not applicable.

AFDC

As a condition of eligibility, all applicants and recipients age 16 or over, except exempt individuals, must register with the Work Incentive Program (WIN) administered by the Department of Labor in localities where the program is available.

As a condition of eligibility non-exempt individuals residing in non-WIN counties, must register with Job Service in Illinois ~~the Illinois State Employment Service (ISES)~~.

As a condition of eligibility, applicants and recipients must provide the Department with verification of the registration with WIN or Job Service.

WIN counties are: Alexander, Champaign, Cook, Macon, Madison, Massac, Peoria, Pulaski, Rock Island, Sangamon, St. Clair, Tazewell, ~~Tazewell,~~ and Winnebago.

Individuals Exempt from Mandatory Registration Requirements

An individual shall be exempt from WIN/Job Service ~~ISES~~ registration requirements when that individual:

- Is a child (does not apply to a caretaker relative) under 16 years of age;
- Is a child (does not apply to a caretaker relative) age 16 through 20 in full-time school attendance;
- Is medically exempt as determined by the local office based on a report from a physician or psychologist and relevant social information;
- Is over 65 years of age;
- Has another household member who requires full-time care of this individual;

RULE 3.31 REGISTRATION/PARTICIPATION REQUIREMENTS (Cont.)

- Has a child under age 6 in the home for whom that individual must provide care;

- Is an adult female with a non-exempt adult male in the assistance unit who is already registered with WIN, or in a non-WIN county, with Job Service ~~ESS~~; or

- Is full-time employed (non-WIN counties only). In WIN counties, individuals who are employed are not exempt due to employment.

WIN Registration

The Department shall refer all non-exempt individuals in counties served by a WIN project to the appropriate WIN office for registration.

All non-exempt applicants must be registered with the WIN program before assistance for those individuals may be authorized.

Non-exempt individuals who are otherwise eligible to be added to an already existing AFDC grant must be registered with WIN before assistance may be authorized.

Non-exempt clients who fail to register with the WIN program are ineligible for assistance. The needs of such individuals shall not be included in the assistance grant. If that individual is the caretaker relative, a protective payment plan shall be initiated; the second adult in the household may not be designated as payee.

~~Non-exempt children age 18 through 20 who are registered with WIN, but are not actively participating in a full-time WIN education or vocational training program shall be ineligible for assistance.~~

WIN Participation

After a client has registered with WIN, the Department shall conduct an employability determination. Upon completion of this determination, the registrant is certified for WIN participation. A client shall be considered a WIN participant once registered with WIN.

RULE 3.31 REGISTRATION/PARTICIPATION REQUIREMENTS (Cont.)

Non-exempt certified WIN registrants who refuse to participate in the WIN program shall be provided counseling for up to 60 days. If the client remains unwilling to participate after this period of counseling, his needs shall be deleted from the grant. If that individuals is the caretaker relative, a protective payment plan shall be initiated; the second adult in the household may not be the payee for the assistance grant.

If the Department of Labor determines that an individual refused to participate in WIN without good cause, their decision shall be binding on the Department. Appropriate action shall be taken by the Department to immediately delete the needs of the client from the assistance grant.

Clients who have been deleted from the assistance grant because of their refusal to participate in the WIN program without good cause, shall be ineligible for assistance for a period of three consecutive months from the termination of their AFDC benefits.

Immediately following this three month period, the client may receive assistance subject to completion of the mandatory registration/participation requirements. When such an individual again receives assistance (after the three month period) and subsequently assistance is discontinued for refusing, without good cause, to participate in the WIN program, that individual shall become ineligible for assistance for a period of six months.

Non-exempt parents whose needs are deleted from the assistance grant due to their failure to participate in the WIN program shall meet the Job Service ~~ISES~~ requirements as a condition of eligibility for the entire assistance unit.

Non-WIN Registration/Participation Requirements

All non-exempt clients in non-WIN counties and all parents or non-exempt children in WIN counties who have been deleted from or not included in assistance grant due to their failure to comply with WIN requirements shall satisfy the following provisions as a condition of eligibility.

AFDC-U fathers, non-exempt AFDC-R mothers (single parent households) and non-exempt AFDC-R fathers shall register with Job Service ~~ISES~~ as a condition of eligibility for the entire assistance unit. Failure to register or willfully presenting oneself to Job Service ~~ISES~~ as unavailable for employment shall result in the denial or cancellation of assistance for the entire assistance unit.

RULE 3.31 REGISTRATION/PARTICIPATION REQUIREMENTS (Cont.)

In addition, such individuals shall be required to maintain current registration with Job Service ~~ISES~~, actively seek employment and accept an offer of suitable and available employment as a condition of eligibility for the entire assistance unit.

All non-exempt individuals, in addition to those specified above, shall register with Job Service ~~ISES~~, maintain current registration, actively seek employment and accept an offer of suitable and available employment as a condition of eligibility. Individuals who fail to meet these requirements shall be ineligible for assistance.

Individuals who have been deleted from the assistance grant, or whose assistance has been cancelled due to their refusal to comply with Job Service ~~ISES~~ requirements shall be ineligible for as long as their refusal persists.

MANG(C)

The above requirements shall apply to MANG(C) applicants and recipients with the exception that MANG(C) applicants and recipients age 16 and over shall not be required to meet the WIN registration/participation requirements.

GA

Registration for Employment

As a condition of eligibility, all applicants for and recipients of General Assistance 16 years of age or over, except for exempt individuals, shall maintain current registration for employment with Job Service in Illinois the ~~Illinois State Employment Service (ISES)~~ as specified below.

Registration with Job Service ~~ISES~~ shall be considered current if the individual has registered or extended registration for employment within the last 60 days. For downstate GA Units in areas where registration is accomplished through an itinerant service, registration shall be considered current if the individual has not registered within the last 60 days but registered for employment on the most recent itinerant service date in that county.

RULE 3.31 REGISTRATION/PARTICIPATION REQUIREMENTS (Cont.)

Individuals Exempt from Mandatory Registration Requirements

An individual is exempt from the Job Service ~~ISES~~ registration requirement when that individual:

Is a child under 16 years of age (does not apply to persons under 16 years of age who are included in the assistance unit as adults);

Is a child 16 or 17 years of age in full-time school attendance (does not apply to persons 16 or 17 years of age who are included in the assistance unit as adults);

Is medically exempt as determined by the local office based on a report from a physician or psychologist and relevant social information;

Is 65 years of age or over;

Has another household member who requires the full-time care of this individual;

Has a child under age 6 in the home for whom that individual must provide care;

Is full-time employed (100 hours a month or more).

Job Service Registration

The Department shall refer all non-exempt individuals, who are not currently registered, to the appropriate Job Service ~~ISES~~ office to register for employment.

All non-exempt applicants shall be currently registered with Job Service ~~ISES~~ before assistance for those individuals may be authorized.

Non-exempt individuals who are otherwise eligible to be added to an existing GA grant shall be currently registered with Job Service ~~ISES~~ before assistance may be authorized.

Failure to Maintain Job Service ~~ISES~~ Registration

Non-exempt GA recipients or caretakers shall maintain current registration with Job Service ~~ISES~~ as a condition of eligibility for the entire assistance unit. Failure to register or willfully

RULE 3.31 REGISTRATION/PARTICIPATION REQUIREMENTS (Cont.)

presenting oneself to Job Service ~~IESS~~ as unavailable for employment shall result in denial or cancellation of assistance for the entire assistance unit.

If a non-exempt client, other than the caretaker in family cases fails to maintain current Job Service ~~IESS~~ registration or willfully presents himself as unavailable for employment, that individual shall be ineligible for assistance.

Responsibility to Seek Employment

In addition to maintaining current registration with Job Service ~~IESS~~, all non-exempt clients must actively seek employment and accept an offer of suitable and available employment as a condition of eligibility.

If a non-exempt GA recipient or caretaker fails or refuses to seek or accept employment, the entire assistance unit shall be ineligible for assistance.

If a non-exempt client other than the caretaker in family cases fails or refuses to seek or accept employment, that individual shall be ineligible for assistance.

Eligibility of Strikers

If a General Assistance client is not working due to a strike, the strike must be sanctioned by union management and not prohibited by law. If the strike is not sanctioned by union management or is prohibited by law, eligibility for General Assistance shall not exist. The client shall register with Job Service ~~IESS~~ and cooperate with the Department's GA Job Placement Unit in Chicago or with Community Work and Training Programs outside the City of Chicago, as a condition of initial and continued eligibility for assistance.

GA (Outside the City of Chicago Only)

Community Work and Training Program

Participation Requirement

All non-exempt GA clients shall accept assignment with the Community Work and Training Program as a condition of eligibility for General Assistance, unless there is good cause for exception.

RULE 3.31 REGISTRATION/PARTICIPATION REQUIREMENTS (Cont.)

The local governmental unit shall cooperate with State and local agencies in establishing employment and training projects and shall itself, establish projects when necessary. Such projects shall provide employment and training in one or a number of local units.

Local GA offices shall initiate, promote and develop projects to provide employment and training for GA clients. Projects shall be approved by the Department. In local units receiving State funds, projects shall be established and approved within 30 days of the date the unit begins to receive State funds. If a GA receiving unit fails to have a project in operation within 30 days, further allocation of State funds may be denied.

GA Job Placement Unit (City of Chicago Only)

The Department shall refer only clients who are immediately employable to its Job Placement Unit. Clients interested in education, training or vocational rehabilitation services shall be referred for such services, if available.

Referral to the GA Job Placement Unit does not replace the requirement that all non-exempt individuals shall maintain current registration with Job Service ~~ISES~~.

Referral

The following groups shall be considered highly employable and therefore, likely candidates for referral:

- Volunteers, who have requested placement services, and who have no observable work limitations.

- Recipients with recent work histories and no observable work limitations.

- Applicants and recipients with minor work limitations.

The GA Placement Unit shall also select clients for call-in and job placement from specially prepared computer listings of active recipients.

Clients shall cooperate with the GA Placement Unit. Failure on the part of GA recipients or caretakers (for family cases) to cooperate with the Job Placement Unit shall result in the cancellation of assistance for the entire assistance unit.

RULE 3.31 REGISTRATION/PARTICIPATION REQUIREMENTS (Cont.)

If an individual, other than the caretaker (in family cases) fails to cooperate with the GA Job Placement Unit, that individual shall be ineligible for assistance.

Initial Employment Expenses

Carfare for transportation to employment referrals and for the initial employment period may be authorized by the Department.

Initial employment expenses may be authorized up to the receipt of the first pay check only.

Food Stamps

Work Registration

Basic Registration Requirements

All non-exempt adults (age 18 through 64) who are eligible members of a food stamp household, shall register for employment and accept suitable employment. Compliance with this requirement is a prerequisite to certification and program benefits shall not be granted conditionally prior to registration by all non-exempt household members.

All non-exempt individuals must register at the time of initial certification and registration must be revalidated at least every six months thereafter.

Registration with and participation in the WIN program shall constitute ~~consititute~~ an equivalent to the food stamp work registration requirement as long as WIN participation is continued.

Each household member who is required to register for employment is also required to:

- Report for an interview at the Job Service ~~ISES~~ office upon reasonable request by that office;

- Provide supplemental information regarding employment status or availability for work when requested to do so by Job Service ~~ISES~~;

RULE 3.31 REGISTRATION/PARTICIPATION REQUIREMENTS (Cont.)

- Report to any employer to whom he has been referred by Job Service ~~IESS~~;

- Accept a bona fide offer of suitable employment which is made as a result of such referral;

- Continue suitable employment to which he was referred by Job Service ~~IESS~~ until:

  . The employment is no longer suitable;
  . The member becomes exempt from work registration; or
  . The member is terminated from the employment due to circumstances beyond his control.

The individuals listed below are exempt from work registration requirements but may, if they wish, voluntarily register for employment.

- Ineligible household members.

- Mothers or other household members having responsibility for the care of a dependent child(ren) under age 18 or the care of an incapacitated adult(s).

- Students who are enrolled at least half time, as defined by the institution in which they are enrolled, in any school or training program which is recognized by any Federal, State, or local governmental agency, i.e., any school or training program having the legal right to give out a certificate of completion.

- Any drug addict or alcoholic who regularly participates as a resident or non-resident in a drug alcoholic treatment and rehabilitation program.

- Persons who are engaged in gainful employment at least 30 hours per week.

- Self-employed persons where the certifying office determines that the employment constitutes a job of at least 30 hours per week on an annual basis.

AMI

Not applicable.

AGENCY: Fair Employment Practices Commission

ACTION: Emergency Adoption of Amendments to Rules and Regulations.

STATUTORY AUTHORITY: Ill. Rev. Stat., ch. 48, §856.05.

EXPLANATION: In response to a growing backlog of charges filed with it, the Fair Employment Practices Commission is revamping its intake and investigative techniques so as to enable it more readily to identify charges which do not state a claim under the FEPA, and to more rapidly resolve charges through investigation and settlement. Because of the magnitude of the present backlog and the volume of new charges it receives daily, the Commission must implement these new techniques on an emergency basis, beginning as of Monday, March 13, 1978.

DESCRIPTION: Under these new procedures, the Commission will conduct more intensive interviews of prospective complainants, administratively close charges in which complainants fail to cooperate, and schedule early fact-finding conferences to obtain evidence and provide an opportunity for rapid settlement of disputes. The new procedures will be implemented through amendments to Articles III and IV of the Commission's Rules and Regulations adopted by the Commission on March 8, 1978.

THE FULL TEXT OF THE AMENDED ARTICLES III AND IV FOLLOWS:

ARTICLE III
Charge

Section 3.1. Time of Filing--A complainant, or the Commission upon a vote of at least three members, may file a charge at any time within 180 days after occurrence of an alleged unfair employment practice. If the alleged unfair employment practice is of a continuing nature, the date of occurrence may be any date subsequent to the commencement of the unfair employment practice up to and including the date on which it shall have ceased.

Section 3.2. Form--A charge shall be in writing and signed by the complainant, or by a member of the Commission in the case of a Commission charge, under oath or affirmation before a notary public or other person authorized by law to administer oaths or affirmations. Notary service shall be provided without cost at the Commission's offices.

Section 3.3. Contents--A charge shall be in such detail as to substantially apprise any party of the time, place and facts with respect to the alleged unfair employment practice. It should contain the following:

(a) The full name and address of the complainant, or a statement that the charge is filed in the name of the Commission in the case of a Commission charge;

(b) The full name and address of the respondent;

(c) A statement of the facts alleged to constitute the unfair employment practice, including the date, time, and place thereof;

(d) A statement describing any other action instituted by or on behalf of the complainant in any other forum, including one instituted under grievance or arbitration provisions of a collective bargaining agreement, based on any of the incidents or practices alleged in the charge.

Section 3.4. Requirements for Charge--In addition to the elements specified in Section 3.3 hereof, an individual may be required to provide the Commission with the following information where available to enable the Commission to determine whether the facts alleged by the individual state a claim of unfair employment practice under the Act:

(a) The approximate number of persons employed by any entity which is sought to be charged in the capacity of an employer;

(b) For each alleged unfair employment practice, a statement of the facts which lead the individual to believe that the practice is or was unlawful;

(c) A statement of each specific harm or injury that the individual has suffered as a consequence of the alleged unfair employment practice.

Section 3.5. Acceptance of Charge--

(a) The Commission shall accept for filing any charge which it receives from an individual in compliance with the foregoing provisions of this Article.

(b) In the event the Commission receives a written statement from an individual which complies substantially with Sections 3.1 and 3.3 hereof, but which is lacking elements specified in Sec-

tions 3.2 and/or 3.4, the Commission may accept and docket the statement as an unperfected charge. The Commission shall then notify the complainant in writing of the elements which must be supplied to perfect the charge. If the individual fails or refuses to perfect the charge as specified, the charge may be dismissed pursuant to Section 4.6 of these Rules and Regulations.

Section 3.6. Amendment--

(a) Notwithstanding any other provisions of these Rules and Regulations, a charge may be deemed sufficient when the Commission receives from a complainant a written statement sufficiently precise to identify the parties and to describe generally the action or practices complained of. A charge or any part thereof may subsequently be amended by the complainant to cure technical defects or omissions (including failure to properly subscribe or swear to the charge as hereinabove provided), or to set forth additional facts or allegations related to the subject matter of the original charge, and such amendments shall relate back to the original filing date.

(b) A charge may be amended by the complainant to substitute or name additional parties respondent, and such an amendment shall relate back to the original filing date, if (i) at the time of the amendment a separate charge could have been filed against such additional respondent; or (ii) such additional respondent had timely notice of the original charge and the fact it might be involved therein.

Section 3.7. Withdrawal of Charge--A charge or any part thereof may be withdrawn by the Complainant upon the consent of the Commission, at any time prior to an order of the Commission dismissing the charge or the issuance by the Commission of a Complaint based on the charge. A complainant's request to withdraw a charge shall be in writing to the Commission and signed under oath or affirmation.

ARTICLE IV
Investigation

Section 4.1. Docketing and Service of Charge--Each charge, once filed, shall be docketed and assigned a case number by the Commission, and a copy of such charge shall, within ten (10) days following the date of filing, be served by the Commission

on the named respondent.

Section 4.2. Maintenance of Employment Records--Notwithstanding any other provision of these Rules and Regulations, once a charge has been served on a respondent, the respondent shall preserve all personnel records, production records and other evidence which may be relevant to the case until the matter has been finally adjudicated.

Section 4.3. Investigation--After a charge has been filed, the Commission's staff shall institute an investigation to ascertain the facts relating to the unfair employment practice alleged in the charge and any amendments thereto. As part of its investigation the Commission may convene a fact-finding conference upon notice of not less than ten (10) days to all parties whose attendance will be required, for purposes of ascertaining the positions of the parties, identifying the issues in dispute, obtaining evidence and determining the likelihood of a negotiated settlement.

Section 4.4. Adjustment During Investigation--If terms of settlement are agreed to between complainant and respondent during the investigation of a charge, the same shall be reduced to writing, signed by the parties and submitted to the Commission for approval. If so approved, the Commission shall thereupon enter an order incorporating the terms of settlement and dismissing the charge pursuant thereto without a finding on the merits of the charge. Said order shall be served by the Commission on all parties.

Section 4.5. Dismissal After Investigation--If after investigation of a charge, the investigative findings indicate that the charge is not supported by substantial evidence or that the Commission lacks jurisdiction of the charge, and this indication is concurred in by the Commission's Executive Director or his designee, the Executive Director shall thereupon cause to be served upon the complainant a Notice of Dismissal. The Notice of Dismissal shall advise the complainant that the charge is recommended for dismissal, and shall state the ground upon which it is to be dismissed, and shall be accompanied by a copy of the written investigation report. The Notice shall further advise that the complainant may object to dismissal of the charge and obtain consideration of the matter by the full Commission, by serving a demand therefor upon the Commission within thirty (30) days of the date of the Notice. If no such timely demand is served by the complainant upon the Commission, the charge shall be deemed dismissed as of the expiration of said thirty-day period, and the parties shall be so notified. In the event the complainant files a timely demand for reconsideration as herein provided, the matter shall be submitted to the full Commission for determination. A complainant's timely demand for reconsideration under this Section may be accompa-

nied by such statement and/or evidence as the complainant may feel supports the charge.

Section 4.6. Failure to Proceed--A complainant has the responsibility to promptly provide the Commission with notice of any change in address or any prolonged absence from that current address so that he or she can be located when necessary during the Commission's investigation and consideration of the charge. In addition, a complainant is responsible for providing the Commission with necessary information and to be available for interviews and conferences, upon reasonable notice or request by the Commission. If a complainant cannot be located or does not adequately respond to reasonable requests by the Commission, the Commission's Executive Director is authorized to dismiss the charge for complainant's failure to proceed; Provided, that the Commission shall first afford the complainant written notice of his or her failure to comply with this Section at the last known address, and shall allow the complainant not less than thirty (30) days to respond thereto. Written notice of any dismissal pursuant to this Section shall be promptly provided by the Executive Director to the complainant and respondent and shall specify the nature of the complainant's noncompliance herewith.

Section 4.7. Commission Finding--After investigation, the Commission's staff shall submit to the Commission each charge which the investigation indicates is supported by substantial evidence, or in which a complainant has filed a timely demand for reconsideration of a Notice of Dismissal as provided in Section 4.5 of these Rules and Regulations. If the Commission finds that it has jurisdiction of the charge and that there is substantial evidence to support the charge, it shall order that conciliation be attempted in accordance with Article V of these Rules and Regulations. Otherwise, it may return the charge for further investigation, or order that the charge be dismissed. In the event that a charge is ordered to conciliation or ordered dismissed, the Commission shall promptly serve notice of such action upon all parties.

-END-

NOTICE BY THE ILLINOIS INDUSTRIAL COMMISSION OF THE PROPOSED AMENDMENTS OF THE RULES GOVERNING PRACTICE BEFORE THE INDUSTRIAL COMMISSION UNDER THE WORKMEN'S COMPENSATION AND OCCUPATIONAL DISEASES ACTS

NOTICE

PLEASE TAKE NOTICE THAT pursuant to Section 16 of the Illinois Workmen's Compensation Act, Illinois Revised Statutes, Chapter 48, the Industrial Commission has proposed to amend the Rules Governing Practice before the Industrial Commission under the Workmen's Compensation and Occupational Diseases Acts as they pertain to filing claims, motions and procedures on review.

DESCRIPTION OF THE SUBJECT MATTER AND ISSUES INVOLVED

The proposed amendments, the full text of which is set forth hereafter, to the Rules Governing Practice before the Industrial Commission under the Workmen's Compensation and Occupational Diseases Acts specifically relate to the filing of claims, motions and procedures on review.

TIME AND MANNER IN WHICH INTERESTED PERSONS MAY PRESENT THEIR VIEWS CONCERNING THE PROPOSED ACTION

Notice is hereby given that all interested persons may submit, in writing, data, views, arguments or comments on the proposed rules. All submissions will be fully considered. Submissions must be received by April 1, 1978, and should be sent to:

Gretchen Wolfe-Benett
Counsel to the Commission
Illinois Industrial Commission
160 North LaSalle Street
Chicago, Illinois 60601

The full text of the rules is as follows:

Amend Rule No. 2-(1) by adding the following:

Rule No. 2-(1) Docketing and Numbering of Cases

All cases brought before the Illinois Industrial Commission shall be docketed, time-stamped and given a letter and number corresponding to the Act under which benefits are claimed and the year of filing. All subsequent pleadings or correspondence shall refer to this letter and number.

All documents filed with the Industrial Commission, including but not limited to Applications for Adjustment of Claim, Attorneys' Appearances, Motions, and Petitions for Review, shall be served on all parties and shall have a certificate of service setting forth time and manner of such service. A copy of all correspondence addressed to the Commission with respect to a pending matter shall be sent to all parties at the time it is sent to the Commission; all such correspondence shall list the parties to whom copies have been sent.

Delete Rule No. 4-(7) Abstract of Record as follows:

Rule No. 4-(7) Abstract of Record (Repealed)

~~On-review-hearing,-subject-to-the-discretion-of-the-reviewing commissioner,-it-may-be-necessary-for-the-reviewing-party-to-file-an abstract-of-the-authenticated-transcript-on-arbitration-within-21-days after-the-initial-review-hearing-date.--The-responding-party-may-file an-additional-abstract-of-transcript-within-15-days-after-the-due-date of-the-initial-abstract.--If-additional-evidence-is-taken-on-a-review hearing,-it-may-also-be-necessary-to-file-an-abstract-of-the-transcript of-proceedings-on-review-within-15-days-after-the-receipt-of-the transcript-from-the-reporter.~~

Delete Rule No. 4-(8) Memorandum/Brief as follows and insert the following in its stead:

~~Rule-No.-4-(8)--Memorandum/Brief~~

~~On-all-cases-other-than-those-where-the-nature-and-extent-of-injury is-the-sole-issue,-where-Oral-Argument-is-requested,-the-reviewing-party must-file-a-memorandum/brief-prior-to-Oral-Argument.--The-memorandum/brief (one-original-and-four-copies)-may-be-in-any-form-but-must-relate-the-Nature-of-the-Case,-Issues-Presented,-Points-and-Authorities-and-Argument and-must-be-filed-not-later-than-30-days-before-the-Oral-Argument-date. The-responding-party-shall-have-15-days-after-receipt-of-the-memorandum/ brief-of-the-reviewing-party-to-file-an-Answer.--A-Reply-memorandum-shall~~

~~be required only if a new matter is raised in the answering brief. In any case where a total permanent disability or death award is entered either party may file a memorandum/brief regardless of the number of issues involved and the requirements herein contained shall apply.~~

~~It shall be absolutely necessary that all Abstracts, Briefs, Answers and Replys bear the name of the Reviewing Commissioner directly under the case number in the caption.~~

Rule No. 4-(8) Summaries, Briefs and Abstracts

A) In all cases in which oral argument is requested, the appellant shall file a summary setting forth: 1) the name and number of the case; 2) the reviewing Commissioner; 3) the Arbitrator; 4) the Arbitrator's findings as to: a) date of accident, b) temporary total compensation awarded and paid, c) medical expenses awarded and d) amount of permanent disability found; 5) appellant's claim of error in the Arbitrator's decision; 6) particular evidence in the record and particular legal authorities which supports appellants claims. Five (5) copies of said summary should be filed with the Commission and served on all other parties not less than fifteen (15) days before the date set by the Commission for oral argument. The Appellee may file and serve on all parties five (5) copies of a response not later than five (5) days before the date of oral argument. Each summary and response shall be written on not more than one side of one piece of paper 8½" x 11" in size and shall have attached a certificate of service setting forth the date and manner of service on all parties. Appellee's summary will be rejected if not filed timely. Oral argument will be limited to the claims of error in the Arbitrator's decision set forth in the summary. Failure of the appellant to file timely the summary required by this rule shall constitute waiver of oral argument by the appellant.

B) In addition to the summary required by paragraph A above the reviewing Commissioner may order appellant to file a Brief/Abstract of the record. The brief (5 copies) may be in any form but must state the nature of the case, the issues presented, points and authorities and argument and shall be filed not later than 30 days before the oral argument date set by the Commission or such other date as set by the reviewing Commissioner. The appellee shall have fifteen (15) days after receipt of the appellant's brief/abstract to file an answer. A reply brief shall be limited to new matters raised in the answering brief. All abstracts, briefs, answers and replies shall bear the name of the reviewing Commissioner directly under the case number in the caption. Failure of appellant to file timely a brief or abstract ordered by the reviewing Commissioner shall constitute waiver of oral argument by appellant. Appellee's answering brief will be rejected if not filed timely.

Delete Rule No. 4-(9) Time for Filing as follows and insert the following in its stead:

~~Rule No. 4-(9) Time for Filing~~

~~All Memorandum/Briefs, Answers and Replies must be filed with the Reviewing Commissioner not later than 10 days prior to the date set for Oral Argument. The Reviewing Commissioner will set the dates required for Memorandum/Brief, Answer and Reply. Except for good cause shown there will be no extensions of time granted for the completed filing of these documents. In the event the initial abstract is not filed within the prescribed period, or filing thereof is not excused by the Reviewing Commissioner, appropriate sanctions will be imposed under Rule 9-(1).~~

Rule No. 4-(9) Continuances for Oral Arguments and Extensions of Time for Filing Summaries, Briefs and Abstracts.

Parties are expected to make their oral arguments at the time and date set by the Commission. No continuance of an oral argument or extension of time for filing a summary, brief, abstract or other document shall be granted except by order of the Commission for good cause shown.

NOTICE BY THE ILLINOIS DEPARTMENT OF INSURANCE

REGARDING PROPOSED RULE 20.07

MINIMUM STANDARDS OF INDIVIDUAL ACCIDENT AND

HEALTH INSURANCE

NOTICE

The Illinois Department of Insurance proposes Rule 20.07 to implement and comply with Section 355a of the Illinois Insurance Code (Ill. Rev. Stat., 1975, ch. 73, para. 967a).

The aforementioned Statute requires the Director of Insurance to issue Rules and Regulations that will provide for reasonable standardization and simplification of terms and coverages of individual accident and health insurance policies in order to facilitate public understanding and comparisons of said policies. Reasonable disclosure in the sale of these policies and the elimination of misleading or confusing provisions which affect the initial purchase of and the subsequent settlement of claims should also be provided for in such Rules and Regulations.

The proposed rule deals with the following subject matters: permissible definitions that may be used with accident and health insurance products; prohibited provisions; minimum benefits by specific types of products; required disclosure provisions; coverage requirements; and replacement requirements.

All policies within the purview of the proposed rule that do not conform to the standards outlined therein with respect to general terms, conditions and specific benefits as prescribed will be publicly identified as nonstandard. The rule will further promote uniformity and eliminate confusion in the market place.

The Director of Insurance will conduct a hearing with respect to proposed rule 20.07 on April 25, 1978 in Room 1600, State of Illinois Building, 160 North LaSalle Street, Chicago, Illinois from 9:30 A.M. to 12:00 noon and from 1:30 P.M. to 4:30 P.M. All interested persons who wish to present their views, comments and data concerning this rule may do so by attending this hearing or by sending written comments to the attention of Mr. Lloyd Rice or Mr. Charles Budinger, Department of Insurance, 213 East Monroe Street, Springfield, Illinois 62767. All interested persons who wish to present their views orally under oath at the hearing must notify the Director of Insurance no later than 5:00 P.M. on April 21, 1978. Any person who fails to file a timely notice will not be permitted to offer oral views except as time permits.

The complete text of proposed Rule 20.07 follows.

ARTICLE XX

ACCIDENT AND HEALTH INSURANCE

Rule 20.07 (Minimum Standards of Individual Accident and Health Insurance)

Section 1. AUTHORITY.

This Rule is issued by the Director of Insurance pursuant to Section 401 of the Illinois Insurance Code which empowers the Director ". . . to make reasonable rules and regulations as may be necessary for making effective . . ." the insurance laws of this State. This Rule implements Section 355a of the Illinois Insurance Code.

Section 2. PURPOSE.

The purpose of this Rule is to establish reasonable standardization and simplification of terms and coverages of individual accident and health insurance policies in order to: facilitate public understanding and comparison; eliminate provisions contained in individual accident and health insurance policies which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims; and provide for full disclosure in the sale of such coverages.

Section 3. APPLICABILITY.

This Rule shall apply to all individual accident and health insurance policies delivered or issued for delivery in this State, after the effective date of this Rule, except that it shall not apply to individual policies issued pursuant to a conversion privilege under a policy of group or individual

insurance when such individual policy includes provisions which are inconsistent with the requirements of this regulation, nor to policies being issued to employees or members as additions to franchise plans in existence on the effective date of this regulation.

The requirements contained in this Rule shall be in addition to any other applicable Rules previously adopted.

Section 4. REVISION OF NONCOMPLYING POLICY FORM AND SUBSCRIBER CONTRACTS CERTIFICATE OF COMPLIANCE REQUIRED.

Any policy as defined in Section 355a of the Illinois Insurance Code previously filed and approved by the Director need not be refiled if such policy is in compliance with the requirements of this Rule. Any previously approved policy which does not comply with the requirements of this Rule must be amended by rider or revised and resubmitted in duplicate with a duplicate letter of transmittal. Amendment riders used for the purpose of compliance with this Rule may continue to be used after three years following the effective date of this Rule only with the approval of the Director.

All forms and contracts required to be revised and resubmitted by this Rule shall be accompanied by a Certificate of Compliance and Consent to Future Discontinuance of Use of Approved Policy Form as required by Illinois Department of Insurance Rule 9.16.

Section 5. DEFINITIONS.

Except as provided hereafter, no individual accident or health insurance

policy delivered or issued for delivery to any person in this State shall contain definitions respecting the matters set forth below unless such definitions comply with the requirements of this Section.

A. "One period of confinement" or "continuous hospital confinement" means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than 90 days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

B. "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

1. The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital;
   a. be an institution operated pursuant to the law; and
   b. be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and
   c. provide 24 hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).
2. The definition of the term "hospital" may state that such term shall not be inclusive of:

a. convalescent homes, convalescent, rest, or nursing facilities; or

b. facilities primarily affording custodial, educational or rehabilitative care or care or treatment for persons suffering from mental diseases or disorders; or

c. facilities for the aged, drug addicts or alcoholics; or

d. any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

C. "Convalescent Nursing Home, " "Extended Care Facility," or "Skilled Nursing facility: shall be defined in relation to its status, facilities and available services.

1. A definition of such home or facility shall not be more restrictive than one requiring that it:

a. be operated pursuant to law;

b. be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

c. be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

d. provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and

e. maintains a daily medical record of each patient.

2. The definition of such home or facility may provide that such term shall not be inclusive of:

a. any home facility or part thereof used primarily for rest;

b. a home or facility for the aged or for the care of drug addicts or alcoholics; or

c. a home or facility primarily used for the care and treatment of mental diseases, or disorders, or custodial or educational care.

D. "Accident," "Accidental Injury," shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

The definition shall not be more restrictive than the following: Injury or injuries, for which benefits are provided, means accidental bodily injuries sustained by the insured person which are the direct casue of loss, independent of disease or bodily infirmity and occurring while the insurance is in force.

NOTE: The fact that the injury combined with other factors to produce the loss does not necessarily relieve the insurer of liability. Each claim must be judged on the basis of its particular facts and in light of the court decisions, to determine whether the injury is to be considered as the cause of the loss.

Such definition may provide that injuries shall not include injuries for which benefits are provided under any workmen's compensation, employer's liability or similar law, motor vehicle no-fault plan, unless prohibited by law, or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

E. "Sickness" shall not be defined to be more restrictive than the following: "Sickness means sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period which will not exceed thirty (30) days from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or disease for which benefits are provided under any workmen's compensation, occupational disease, employer's liability or similar law."

F. "Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

G. "Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician." The use of such terms requires an

insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws dealing with physician licensure.

H. "Total Disability"

1. A general definition of total disability cannot be more restrictive than one requiring the individual to be totally disabled from engaging in any employment or occupation which he could, giving due consideration to his education, training or experience be reasonably expected to engage in and is not in fact engaged in any employment or occupation for wage or profit.

2. Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to: (a) Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation," (b) Engage in any training or rehabilitation program.

3. An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of his regular occupation or words of similar import. An insurer may require care by a physician other than the insured or a member of the insured's immediate family.

4. When through a specific provision of a policy, disability coverage is provided to a retired person, such definition shall not require more than the insured be completely unable to engage in the normal activities of a retired person of like age and good health.

I. "Partial Disability" shall be defined in relation to the individual's

inability to perform one or more but not all of the "major," "important," or "essential" duties of employment or occupation or may be related to a "percentage" of time worked or to a "specified number of hours" or to "compensation." Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

J. "Residual Disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important," or "essential duties" of employment or occupation, or to the inability to perform all usual business for as long as is usually required. A policy which provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or other term of similar import which in the opinion of the Director adequately and fairly describes the benefit.

K. "Medicare" shall be defined in any hospital, surgical or medical expense policy which relates its coverage to eligibility for Medicare or Medicare benefits. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Laws 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act," as then constituted and any later amendments or substitutes thereof" or words of similar import.

L. "Mental or Nervous Disorders" shall not be defined more restrictively than

a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Section 6. PROHIBITED POLICY PROVISIONS.

A. Except as provided in Section 5E, no policy shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy subject to the further exception that a policy may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting therefrom for hernia, varicose veins, adenoids, appendix and tonsils. However, the permissible six (6) months exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting period.

B. No policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment is offered to the policyholder as an alternative to such dividend policy or rider. No such dividend policy or rider shall be issued for an initial term of less than six (6) months.

C. A disability policy, hospital confinement policy or specified disease policy may contain a "return of premium" or "cash value benefit" so long as:

1. The policy provides for a return of 100% of all premiums paid less the claims incurred by the time the insured attains age 65. A percentage of less than 100%, but greater than 50%, is permissible if the "return of premium" or "cash value benefit" has been in force for 10 years or less;
2. The policy contains a reasonable nonforfeiture benefit and provided for the value to be paid automatically upon lapse or death;

3. The surrender value percentages are not less than those calculated assuming 1958 CSO Mortality, 5% interest, 5 year preliminary term;

4. An acceptable method of reserving is approved by the Director concurrent with approval of the policy. Reserves should exceed or equal the cash value at all durations;

5. The surrender value percentages are calculated assuming a zero percent future claim offset;

6. The surrender value percentages are defined for all policy years, (surrender value percentages may be shown only for the first twenty policy years, but under these conditions the contract must define the method used to determine the surrender value percentages after the twentieth contract year);

7. The interim surrender value percentages are defined when premiums are paid within a contract year;

8. The policy does not tie the return of premium to anything less than 100% of the premiums paid less claims paid.

D. Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the Federal Government for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

E. No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows or as may be approved by the Director from time to time:

1. Preexisting conditions or diseases;

2. Mental or emotional disorders, alcoholism and drug addiction;

3. Pregnancy, except for complications of pregnancy;

4. Illness, treatment or medical condition arising out of:

   a. war or act of war (whether declared or undeclared; participation in a felony, riot or insurrections; service in the armed forces or units auxillary thereto,

   b. suicide (sane or insane), attempted suicide or intentionally self-inflicted injury,

   c. aviation,

   d. with respect to short-term nonrenewable policies, interscholastic sports;

5. Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part.

6. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet.

7. Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workmen's compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.

8. Dental care or treatment;

9. Eye glasses, hearing aids and examination for the prescription or

fitting thereof;

10. Rest cures, custodial care, transportation and routine physical examinations;

11. Territorial limitations.

F. No provision of this Rule shall prohibit the use of any policy provision which is required or permitted by statute. Other provisions of this Rule shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page of the policy or unless notice of the waiver appears on the first page or specification page.

G. No policy, rider or endorsement, providing benefits for loss due to an accident or accidental injury shall contain a provision or clause limiting, reducing or excluding liability for a loss resulting from purely accidental circumstances (e.g. involuntary or unintentional ingestion of poison or inhalation of poisonous gases or fumes.) This restriction shall not preclude the exclusion of loss due to suicide or attempt thereat by properly drawn language nor shall it preclude approval of a benefit for loss from defined accidents, such as travel, sport and student accident insurance.

H. Policy provisions precluded in this Section shall not be construed as a limitation on the authority of the Director to disapprove other policy provisions in accordance with Insurance Code Section 143, paragraph 1, which, in the opinion of the Director, are unjust, unfair, or unfairly discriminatory to the policyholder, beneficiary, or any person insured under the policy.

Section 7. ACCIDENT AND HEALTH MINIMUM STANDARDS FOR BENEFITS.

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. No individual policy of accident and health insurance shall be delivered or issued for delivery in this State which does not meet the required minimum standards for the specified categories unless the Director finds that such policies are approvable as Limited Benefit Health Insurance and the Outline of Coverage complies with the appropriate outline in Section C of this Rule. Nothing in this Section shall preclude the issuance of any policy combining two or more categories of coverage set forth in Insurance Code Subsection 4 of Section 355a.

A. General Rules --

1. A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. The policy shall provide that in the event of the insured's death the spouse of the insured, if covered under the policy, shall become the insured.

2. The terms "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Section 8A.1. The terms "noncancellable" or "noncancellable and guaranteed renewable" shall be defined as in Rule 20.03.

3. In a family policy covering both husband and wife the age of the

younger spouse must be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit (e.g., age 65) so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in said definition.

4. If a policy contains a status type military service exclusion or a provision which suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to such person on a pro rata basis.
5. In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.
6. Policies providing convalescent or extended care benefits following hospitalization shall not condition such benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital.
7. Any medical, surgical or other expense benefit for the recipient insured in a transplant operation may specify the limits for such specific benefit relating to donors or shall provide reimbursement of such expense of the live donor to the extent that such benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.
8. A policy may contain a provision relating to recurrent disabilities

provided, however, that no such provision shall specify that a recurrent disability be separated by a period greater than six (6) months.

9. Any pre-existing condition exclusion must be administered in accordance with Rule 20.05 when a definition of preexisting condition(s) is required by Section 5 of Rule 20.05, for purposes of readability, the Rule may be summarized in the appropriate policy provision by a definition reading substantially as follows:

"A pre-existing illness (condition) means any condition that was diagnosed or treated by a physician within 24 months prior to the effective date of the coverage or produced symptoms within 12 months prior to the effective date of coverage that would have caused an ordinarily prudent person to seek medical diagnosis, care or treatment."

10. Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy which the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the policy was in force.

11. Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

12. Any accident only policy providing benefits which vary according to the type of accidental cause shall prominently set forth in the outline of

coverage the circumstances under which benefits are payable which are lesser than the maximum amount payable under the policy.

13. Termination of the policy shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period the policy was in force may be limited to a period of one year for health care beneits, limited to the duration of the policy benefit period (if any) and/or limited to payment of the maximum benefits.

14. All policies issued after the effective date of this rule, whether or not such policy contains the refund provision, shall be administered to provide a refund of any unearned premiums upon death of any insured member from date of death if the Company receives a written request for unearned premium from the policyowner or the person entitled thereto.

B. Basic Hospital Expense Coverage

"Basic Hospital Expense Coverage" is a policy of accident and health insurance which provides coverage for a period of not less than thirty-one (31) days during any continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:

1. Daily hospital room and board in an amount not less than the lesser of (a) 80% of the charges for semi-private room accommodations or (b) $50.00 per day;

2. Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either 80% of the

charges incurred up to at least $1,000.00 or ten times the daily hospital room and baord benefits; and

3. Hospital outpatient services consisting of (a) hospital services on the day surgery is performed, and (b) hospital services rendered within 72 hours after accidental injury, in an amount not less than $50.00, and (c) X-ray and laboratory tests to the extent that benefits for such services would have been provided to an extent not less than $100.00 if rendered to an in-patient of the hospital.

4. Benefits provided under (1) and (2) of (B) above, may be provided subject to a combined deductible amount not in excess of $100.00.

C. Basic Medical-Surgical Expense Coverage

"Basic Medical-Surgical Expense Coverage" is a policy of accident and health insurance which provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

1. Surgical services:

   a. in amounts not less than those provided on a fee schedule based on the relative values contained in the state of New York certified surgical fee schedule, or the 1964 California Relative Value Schedule or other acceptable relative value scale of surgical procedures, up to a maximum of at least $500.00 for any one procedure; or

   b. not less than 80% of the reasonable charges.

2. Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or his

assistant) performing the surgical services:

a. in an amount not less than 80% of the reasonable charges; or

b. 15% of the surgical service benefit.

3. In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than 80% of the reasonable charges; or $5.00 per day for not less than twenty-one (21) days during one period of confinement.

D. Hospital Confinement Indemnity Coverage

"Hospital Confinement Indemnity Coverage" is a policy of accident and health insurance which provides for not less than $30.00 per day and for not less than thirty-one (31) days during any one period of confinement for each person insured under the policy. The policy may contain a benefit limit less than $30.00 per day if the policy benefit period is extended to reflect a maximum amount payable under a $30.00 per day policy with a thirty-one day maximum confinement period for any one period of confinement.

E. Major Medical Expense Coverage

"Major Medical Expense Coverage" is an accident and health insurance policy which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than $10,000.00; co-payment by the covered person not to exceed 25% of covered charges; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of such bases not to exceed 5% of the aggregate maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance in which case such deductible may be increased

by the amount of the benefits provided by such underlying insurance, for each covered person. The aggregate maximum shall be increased not less than $3.00 for each $1.00 by which the deductible exceeds the minimum. Major medical expense insurance must provide for each covered person coverage of:

1. Daily hospital room and board expenses, prior to application of the co-payment percentage, for not less than $50.00 daily or, in lieu thereof, the average daily cost of semi-private room rate in the area where the insured resides, for a period of not less than thirty-one days during any period of continuous hospital confinement;
2. Miscellaneous Hospital Services, prior to application of the co-payment percentage, for an aggregate maximum of not less than $1,500.00 or 15 times the daily room and board rate if specified in dollar amount;
3. Surgical Services, prior to application of the co-payment percentage, to a maximum, of not less than $600.00 for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount; anesthetic services, prior to application of the co-payment percentage of at least 15% of the covered surgical fees or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthetic services at the same unit value as used for surgical schedule;
4. Doctor visits, in or out of the hospital with minimum dollar amounts per visit, prior to application of the co-payment percentage, equal to not less than $8.00 per visit, covering not less than one visit per day and for an aggregate maximum of such covered charges of not less than $600.00;
5. Out of Hospital Diagnostic X-rays and Tests, prior to application of

the co-payment percentage, for an aggregate maximum of such covered charges of not less than $600.00;

6. Not fewer than 3 of the following additional benefits, prior to application of the co-payment percentage for an aggregate maximum of such covered charges of not less than $1,000.00;

   a. private duty registered, or if not available, licensed practical nurse services performed by other than a family member while insured is hospital confined;

   b. convalescent nursing home;

   c. diagnosis and treatment by radiologist or physiotherapist;

   d. rental of special medical equipment, as defined by the insurer in the policy;

   e. artificial limbs or eyes, casts, splints, trusses or braces;

   f. treatment for functional nervous disorders, and mental or emotional disorders;

   g. out of hospital prescription drugs and medications.

F. Disability Income Protection Coverage

"Disability Income Protection Coverage," is a policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination thereof which has a maximum period of time for which it is payable during disability of at least six (6) months. A disability income protection policy may provide for reduction by the amount of Social Security benefits at inception of any claim but no benefit reduction shall be permitted to offset a Social Security benefit increase during a benefit period.

G. Accident Only Coverage

"Accident Only Coverage" is a policy of accident insurance which provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under such a policy shall be at least $1,000.00 and a single dismemberment shall be at least $500.00.

H. Specified Disease Coverage

1. "Specified Disease Coverage" is a policy which provides coverage for each person insured under the policy for a specifically named disease (or diseases) with a waiting period of not more than 30 days and with a deductible amount not in excess of $250.00 and an overall aggregate benefit limit of not less than $5,000.00 and a benefit period of not less than two (2) years.

2. "Specified Accident Coverage" is an accident insurance policy which provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than $1,000.00 for accidental death; $1,000.00 for double dismemberment and $500.00 for single dismemberment.

I. Limited Benefit Health Insurance Coverage

"Limited Benefit Health Insurance Coverage" is any policy or policies which provide benefits that are less than the minimum standards for benefits required under Section 7B, C, D, E, F, G and H. Such policies or contracts may be delivered or issued for delivery in this State only if the outline of coverage required by Section 8B of this Rule is completed and delivered as required by Section 8 of this Rule.

J. Non-Conventional Coverage: Nothing contained in this Section shall

prohibit the issuance of a policy that does not fall within paragraph A through I if such policy is either experimental in nature or is demonstrated to be a type of coverage that will fulfill a reasonable need of a person or persons to be insured and is appropriately and prominently described in the outline of coverage.

K. The requirements of this Section 7 do not apply to policies issued in compliance with Insurance Code Section 363.

Section 8. REQUIRED DISCLOSURE PROVISIONS.

A. General Rules

1. Each individual policy of accident and health insurance shall include a renewal, continuation, or nonrenewal provision. The language or specificiations of such provision must be consistent with the type of policy to be issued. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

2. Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the

policy term must be agreed to by the insured, except if the increased benefits or coverage is required by law.

3. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

4. A policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

5. If a policy contains any limitations with respect to preexisting conditions, such limitations must appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

6. All accident only policies shall contain a prominent statement on the first page of the policy or attached thereto in either contrasting color or in boldface type at least equal to the size of type used for policy captions, a prominent statement as follows:

"This is an accident only policy and it does not pay benefits for loss from sickness."

7. All policies, except single premium nonrenewal policies, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance, that the policyholder shall have the right to return the policy within ten (10) days of its delivery and to have the premium refunded if after examination of the policy the policyholder is not satisfied for any reason.

8. If age is to be used a a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued,

such fact must be prominently set forth in the outline of coverage.

9. If a policy contains a conversion privilege, it shall comply, in substance, with the following: the caption of the provision shall be "Conversion Privilege," or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

B. Outline of Coverage Requirements for Individual Coverages

No individual accident and health insurance policy shall be delivered or issued for delivery in this State unless an appropriate outline of coverage, as prescribed in Section 8C, is completed as to such policy and:

1. In the case of a direct response insurance product is delivered with the policy, or

2. In all other cases is delivered to the applicant at the time application is made and acknowledgement of receipt or certification of delivery of such outline of coverage is provided to the insurer.

In the event that a policy is issued on a basis other than that applied for, an outline of coverage properly describing the policy must accompany the policy when it is delivered and contain the following statement, in not less than twelve (12) point type, immediately above the company name: "NOTICE" Read this outline of coverage carefully. It is <u>not</u> identical to the outline of coverage provided upon application and the coverage originally applied for

has not been issued."

In those cases where a policy designed to supplement existing coverage is approved, the outline of coverage shall prominently state that coverage is designed to supplement other health insurance policies owned by the insured.

C. Outline of Coverage

The requirement of the outline of coverage shall include the following information:

1. The name and principal address of the insurer.
2. A statement of identification of the policy as described in Section 7 of this Rule.
3. A description of each of the principal benefits and coverages, including the benefit amounts, duration or limits, elimination periods, inner limits and any other items appropriate to the coverage provided.
4. A description of the terms and conditions of renewability of the policy, including any limitations by age, time or event, rights to change premium, status requirements and any other matters appropriate to the terms and conditions of renewability (including any rights of cancellation reserved to the insurer).
5. A description of the principal exceptions, reductions and limitations contained in the policy, including the preexisting conditions, if any, and the circumstances under which any reduction provisions become operative.
6. A statement that the Outline of Coverage is only a brief summary of the policy and is not the contract of insurance. The policy itself sets forth the rights and obligations of the insured and insurer.

Section 9. REQUIREMENTS FOR REPLACEMENT.

A. Application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and helth insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

B. Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in C. below. One (1) copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in D.

In no event, however, will such a notice be required in the solicitation of the following types of policies: accident only and single premium nonrenewable policies.

C. The notice required by B above for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT

OF ACCIDENT AND HEALTH INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by (Company Name) Insurance Company. For your own information and protection, you should be aware of and seriously

D. The notice required by B above for a direct response insurer shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT

OF ACCIDENT AND HEALTH INSURANCE

According to (your application) (information you have furnished) you intend to lapse or otherwise terminate existing accident and health insurance and replace it with the policy delivered herewith issued by (Company Name) Insurance Company. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but is is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could

consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____

Date

_____

Applicant's Signature

cause an otherwise valid claim to be denied. Carefully check the application and write to (Company Name and Address) within 10 days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____

Company Name

Section 10. SEPARABILITY.

If any provision of this Rule or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the Rule and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 11. EFFECTIE DATE.

This Rule shall become effective on 1978 and shall be applicable to all individual accident and health insurance policies delivered or issued in this State on or after such date.

DEPARTMENT OF REGISTRATION EDUCATION

NOTICE of proposed amendment of the Rules and Regulations Promulgated for the Administration of the Illinois VETERINARY MEDICINE AND SURGERY PRACTICE ACT: Amendment of Rule I - APPLICATION FOR EXAMINATION.

NOTICE

PLEASE TAKE NOTICE THAT the Department of Registration and Education pursuant to Section 8(3) of the Illinois Veterinary Medicine and Surgery Practice Act, as amended (Ill.Rev.Stat. 1975, Ch. 91, Par. 124.8(3)), proposes to amend Rule I - Application for Examination, of the Rules and Regulations Promulgated for the Administration of the Illinois Veterinary Medicine and Surgery Practice Act.

DESCRIPTION OF THE SUBJECT MATTER INCLUDED

The amendment, if adopted, will change Rule I to require applications for examination to be filed with the Department 60 days prior to the date of examination instead of 30 days prior to the date of examination as is now required.

TEXT OF PROPOSED AMENDMENT

RULE I - APPLICATION FOR EXAMINATION

An applicant for licensure to practice veterinary medicine and surgery shall file, with the Department of Registration and Education ("the Department"), subject as provided in the last paragraph of Section 6 of the Veterinary Medicine and Surgery Practice Act, as at any time in force in the State of Illinois ("the Act"), at its office in Springfield, Illinois, application therefor on forms prepared and furnished by the Department, fully completed with the information requested thereon, at least ~~thirty (30)~~ sixty (60) days prior to the date of examination and shall file concurrently therewith the following:

1. Certified records which show that such applicant has successfully completed at least two years of pre-veterinary collegiate training at a school, college, university or department of a university approved by the Department.

2. Certified records of a veterinary school, college, university or department of a university or other institution ("Veterinary College") approved by the Department, attended by such applicant which show that such applicant has completed a four year course in veterinary medicine and surgery approved by the Department. (Such records may be mailed directly to the Department by such Veterinary College.)

3. Such applicant's original diploma of graduation from a Veterinary College approved by the Department in which the applicant completed his course of training. In lieu of presenting such diploma with such application, the applicant may present it to the Department at the date of the examination, or prior thereto, and prior to being admitted to take such examination.

TEXT OF PROPOSED AMENDMENT

4. Recommendations from two (2) veterinarians licensed to practice in any state of the United States or in the District of Columbia, certifying as to the good moral character and temperate habits of such applicant.

5. A recent photograph of such applicant, passport size, signed by the applicant and the two (2) veterinarians licensed to practice in any state of the United States, or in the District of Columbia, who signed said recommendations.

6. Fee for examination and license provided by the statutes of the State of Illinois in such case made and provided.

TIME AND MANNER IN WHICH
INTERESTED PERSONS MAY PRESENT
THEIR VIEWS CONCERNING THE
PROPOSED ACTION

Notice is hereby given that all interested persons may submit in writing, data, views, arguments or comments on the proposed amendment. All material submitted will be fully considered. This material must be received within 45 days of the date of this issue of the Illinois Register and should be sent to:

Illinois Veterinary Examining Committee
Department of Registration and Education
55 East Jackson Boulevard, 17th Floor
Chicago, Illinois 60604

ILLINOIS HEALTH FACILITIES PLANNING BOARD

NOTICE

of the proposed Chapter 1 of the Illinois Health Facilities Planning Board, RULES OF ORGANIZATION OF THE ILLINOIS HEALTH FACILITIES PLANNING BOARD, which is being promulgated pursuant ot Section 4.01 of the Administrative Procedures Act.

The proposed Chapter 1, RULES OF ORGANIZATION OF THE ILLINOIS HEALTH FACILITIES PLANNING BOARD, will outline the structure of the Illinois Health Facilities Planning Board and the Rules and operation of the Board. A complete text of the proposed Chapter 1, follows.

On March 3, 1978, the Illinois Health Facilities Planning Board voted the proposed Chapter 1, RULES OF ORGANIZATION OF THE ILLINOIS HEALTH FACILITIES PLANNING BOARD, to Public Hearings. The Public Hearings on the proposed Chapter 1 are scheduled for the following times, dates and locations:

2:00 p.m. on Tuesday, May 16, 1978, at the State of Illinois, Department of Registration and Education Building, located at 55 East Jackson Street in Chicago, Illinois; and

6:30 p.m. on Wednesday, May 17, 1978 at the State of Illinois, Department of Transportation Building, located at 2300 South Dirksen Parkway in Springfield, Illinois.

Interested persons may appear at these Public Hearings and present either oral or written comments and views on the proposal. In addition, comments may be submitted in writing to George A. Lindsley, M.P.H., Executive Secretary of the Illinois Health Facilities Planning Board, Division of Planning and Conformance, Illinois Department of Public Health, 525 West Jefferson Street, Springfield, Illinois 62761, prior to May 16, 1978.

CHAPTER NO. 1

RULES OF ORGANIZATION OF THE ILLINOIS HEALTH FACILITIES PLANNING BOARD

1.01 Name, Statutory Authority, and Composition

NAME: The Health Facilities Planning Board, hereinafter called the "State Board".

STATUTORY AUTHORITY: The Illinois Health Facilities Planning Act, Public Act 78-1156, approved August 27, 1974, as amended hereinafter called the "Act".

COMPOSITION: The State Board shall consist of 13 voting members and three nonvoting exofficio members. The Act stipulates that the Directors of the Illinois Departments of Public Aid, Mental Health and Public Health, as their designated representatives shall serve as the exofficio nonvoting representative. The Act further specifies that of the 13 voting members 7 be consumers. A consumer is defined as any person other than a person (a) whose major occupation currently involves or whose official capacity within the last 5 years has involved the providing, administering or financing of any type of health care facility, (b) who is engaged in health research or the teaching of health, (c) who has a material financial interest in any activity which involves the providing, administering or financing of any type of health care facility, or (d) who is or ever has been a member of the immediate family of the person defined by (a), (b), or (c).

The remainder of the voting members of the Board shall consist of one member representing the commercial health insurance industry in Illinois; one member representing the hospital service corporations in Illinois; one member who is actively engaged in the field of hospital management; one member who is a professional nurse registered in Illinois; one member who is a physician in active private practice licensed in Illinois to practice medicine in all of its branches; and one member who is actively engaged in the field of skilled nursing or intermediate care facility management.

1.02 Appointment and Terms of Office

APPOINTMENT AND TERMS: Members shall be appointed and confirmed in the manner provided in the Act, and for such terms as provided therein.

The Governor shall designate the date of expiration of the term of each member. A member shall continue to serve following the expiration of the term of office until he or she has been re-appointed and qualified or a successor has been appointed and qualified.

Nonvoting ex officio members are Directors of Departments and shall serve for such time as he or she is director.

1.03 Officers and Committees

OFFICERS: The State Board shall select a Chairman and Vice Chairman and such other officers as deemed necessary.

The term of office shall be one year from the date of selection. The incumbent officers shall serve until the State Board has acted on the selection of officers for the ensuing year.

COMMITTEES: The Chairman, acting for the State Board, will establish such standing and/or special committees as are deemed necessary. The Chairman shall specify the duties of committees and appoint the members.

1.04 Executive Secretary

EXECUTIVE SECRETARY: The Executive Secretary of the State Board shall be named by the Director of the Department of Public Health (State Agency), with concurrence of the State Board. The Executive Secretary shall be a person qualified in health care facility planning and in administration.

The Executive Secretary shall be the chief executive officer of the State Board, responsible to the Chairman and, through the Chairman, responsible to the State Board for the execution of its policies and procedures. The working title of this position and office shall be Executive Secretary, Office of the Illinois Health Facilities Planning Board.

The Executive Secretary shall be employed and paid by the State Agency in accordance with the provisions of the Illinois personnel Code, and be responsible to carry out the duties assigned to the State Agency by the Act.

The Executive Secretary shall, on behalf of the State Board, have responsibility and commensurate authority to perform duties, including but not limited to, the following:

1. provide staff and administrative services for the State Board; report periodically to the State Board on staffing, budgetary, and administrative resources and needs.

2. recommend to the State Board its policies and procedures for implementing the provisions and purposes of the Illinois Health Facilities Planning Act.

3. execute and administer the program in accordance with State Board policies, procedures and directives.

4. plan, with the Chairman, all meetings of the State Board and prepare the tentative agenda for State Board approval.

5. maintain all records, files, and reports required by the State Board.

6. as the agent of the State Board, and in the manner it prescribes, prepare all contracts and agreements to which the State Board is a party. The Chairman of the State Board shall co-sign with the Director of the Department of Public Health all contracts and agreements.

7. represent the State Board whenever necessary; write and issue letters and other communications on its behalf.

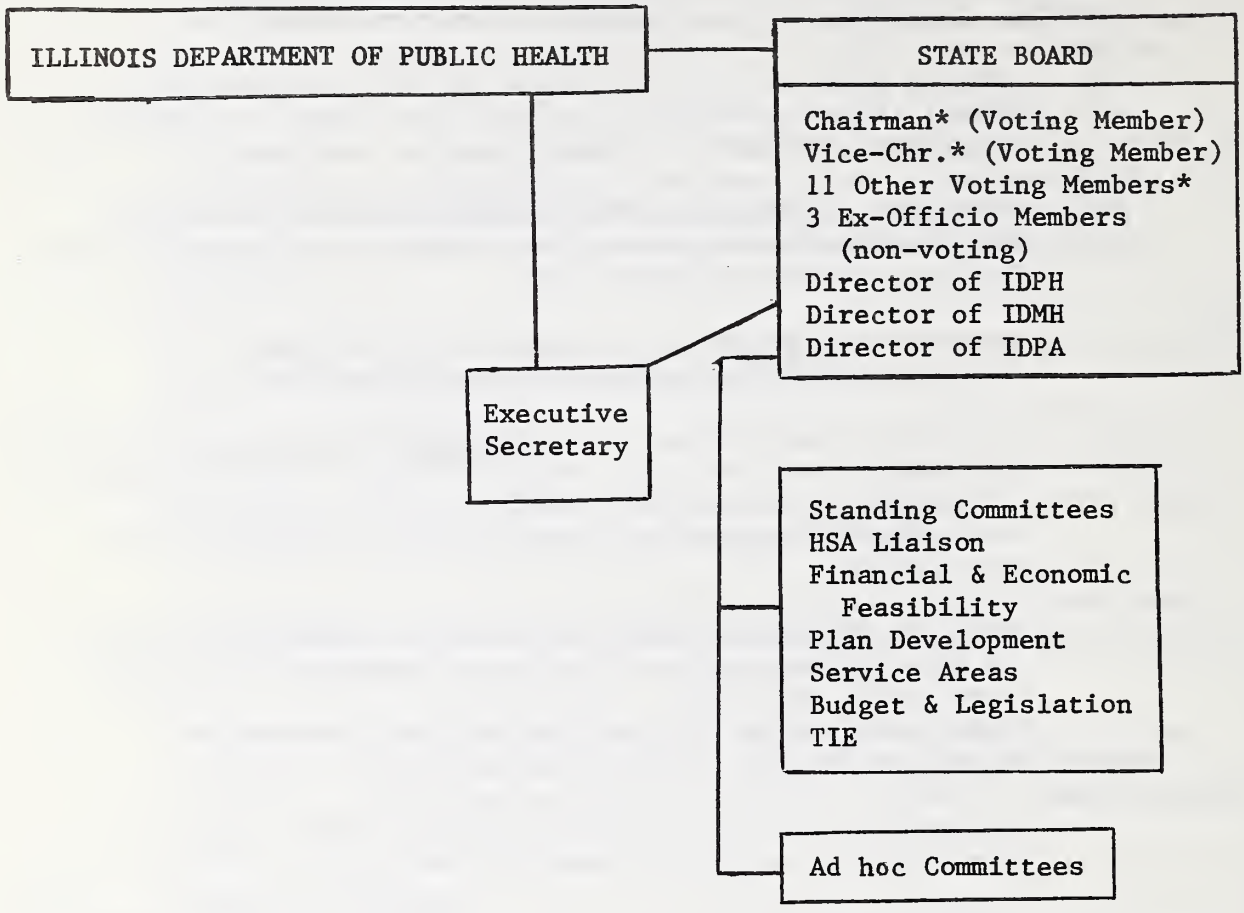
8. perform other duties as directed by the State Board, or by its Chairman.

1.05 Description and Chart of State Board Organization

(a) Description: The State Board is organized as heretofor set forth in this Rule.

(b) Chart of Organization of the State Board.

(over)



*Public Act 78-1156 requires that the 13 voting members of the State Board represent the following:

Consumers - 7 members
Commericial Health Insurance - 1 member
Hospital Service Corporation - 1 member
Long-Term Care Management - 1 member
Hospital Management - 1 member
Professional Nursing - 1 member
Physicians - 1 member

1.06 Meetings

(a) As provided in An Act in Relation to Meetings (Ill. Rev. Stat., Chap. 102, Sec. 41-44) all decisions of the State Board shall be made at meetings open to the public.

(b) The State Board shall keep a complete and accurate record of all meetings including the votes of individual members on all matters before it.

(c) Regular and special meetings shall be called by the Chairman through the Executive Secretary.

(d) The State Board shall meet at least once each quarter, or as often as the Chairman of the State Board deems necessary, or upon the request of the majority of the members.

(e) The State Board shall, in the scheduling and conduct of its meetings, comply with the provisions of "An Act in Relation to Meetings" (Ill. Rev. Statute., Chap. 102, Sec. 41-44), as heretofore or hereafter amended, specifically that the State Board shall adopt at the beginning of each fiscal year a schedule of meetings which shall state the regular dates, times, and places of such meetings.

(f) Public notice of regular meetings shall be given by posting a copy of the notice at the office headquarters of the State Board and supplying notice to media requesting such information under the Meetings Act.

(g) The State Board through its Executive Secretary, shall at the beginning of each fiscal year, prepare and make available a schedule of all its regular meetings for such fiscal year, listing the times and places of such meetings. If a change is made in regular meeting dates, at least 10 days notice of such change shall be given by publication in a newspaper of general circulation, with notice of such change posted at the principal office, and supplied to those media that have requested annual information.

(h) Special meetings may be called by the Chairman or a majority of State Board members upon at least 24 hours written notice to each member. Public notice of all special meetings, rescheduled regular meetings, or reconvened meetings shall

be given at least 24 hours before such meetings, except that public notice of reconvened meetings does not apply to any case where the meeting is to be reconvened within 24 hours, nor to any case where announcement of the time and place of the reconvened meeting was made at the original meeting, and there is no change in the agenda.

1.07 Quorum

QUORUM: Seven voting members of the State Board shall constitute a quorum. The affirmative vote of seven of the voting members of the State Board shall be necessary for any action requiring a vote to be taken by the State Board. A vacancy in the membership of the State Board shall not impair the right of a quorum to exercise all the rights and perform all the duties of the State Board as provided for in the Act.

1.08 Table of Rules

(a) Pursuant to Section 4.01(a)3 of the Administrative Procedures Act, as amended, the following table of rules of the State Board is provided to aid users in finding and using the State Board rules currently in force:

STATEMENT OF INTENT, PURPOSE, GOALS AND OBJECTIVES

RULE 1 RULES OF ORGANIZATION OF THE ILLINOIS HEALTH FACILITIES PLANNING BOARD

RULE 2 RULE FOR THE OCTOBER 1, 1974, EXEMPTION

RULE 3 THE ILLINOIS HEALTH CARE FACILITIES PLAN

RULE 3B THE ILLINOIS LONG-TERM CARE AND CHRONIC DISEASE AND FACILITIES PLAN

RULE 4 RULE FOR PROCESSING APPLICATIONS FOR PERMIT FILED BY HOSPITALS

RULE 4B RULES FOR PROCESSING APPLICATIONS FOR PERMIT FILED BY LONG-TERM CARE, CHRONIC DISEASE, AND REHABILITATION FACILITIES

RULE 5 CRITERIA AND PROCEDURE FOR RECOGNITION OF AREAWIDE HEALTH PLANNING ORGANIZATION FOR HEALTH FACILITY PLANNING

RULE 6 FAIR HEARINGS RULES AND PROCEDURES

RULE 7 PERMIT APPLICATION FEES

RULE 8 PROCEDURE FOR PUBLIC NOTICE AND HEARING

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RULE 6 FAIR HEARINGS RULES AND PROCEDURES

RULE 7 PERMIT APPLICATION FEES

RULE 8 PROCEDURE FOR PUBLIC NOTICE AND HEARING

RULE 9 STANDARDS AND CRITERIA FOR REVIEW OF APPLICATIONS FOR PERMIT FOR TECHNOLOGICALLY INNOVATIVE EQUIPMENT

GUIDELINES FOR CT SCANNERS

RULE 10 REPEALED

RULE 11 FINANCIAL AND ECONOMIC FEASIBILITY REVIEW AND EVALUATION

RULE 11B FINANCIAL AND ECONOMIC FEASIBILITY REVIEW AND EVALUATION

1.09 Procedures For the Public to Obtain Information

(a) Pursuant to Section 4.01(a)2 of the Administrative Procedures Act, as amended, the public can obtain information or make submissions or requests on subjects, programs or activities of the State Board by contacting the Executive Secretary at the official headquarters.

1.10 Petition for Adoption of Rules

(a) Pursuant to the requirements of Section 8 of the Administrative Procedures Act, as amended, any interested person may petition the State Board requesting the promulgation, amendment or repeal of a rule.

(b) The form of the petition, which may be handwritten or typewritten, shall be essentially as follows:

(1) Name, title (if any), organization (if any), address, and telephone number of the petitioner.

(2) Nature of action sought, i.e., promulgation of a rule, amendment of a rule, or repeal of a rule.

(3) Proposed text of the rule or amendment or identification of the rule to be repealed.

(4) Brief statement of the rationale for the requested action.

(c) Such petitions are to be sent or delivered to the Executive Secretary at 525 West Jefferson, 5th Floor, Springfield, Illinois 62761, or to the Illinois Department of Public Health which shall refer them to the Executive Secretary.

(d) Such petitions shall be handled as follows:

(1) If received at least two weeks prior to a scheduled regular meeting of the State Board, the petition will

be placed on the agenda of that meeting for referral to a committee of the State Board or alternative action.

(2) If received less than two weeks prior to a scheduled regular meeting of the State Board, the petition will be carried over to the next following scheduled regular meeting and then placed on the agenda for referral to a committee of the State Board or alternative action.

(3) The Executive Secretary will send copies of the petition to the members of the State Board as soon after receipt as is practicable.

(4) If, after submission of the petition to the State Board at its regular meeting or within 30 days after submission of the petition, whichever period of time is the longer, the State Board has not initiated rule-making proceedings in accordance with Section 5 of the Administrative Procedures Act, as amended, the petition shall be deemed to have been denied.

1.11 Items Warranting State Board Action

(a) Matters on which the State Board shall deliberate and vote shall include, but not be limited to, the following:

(1) Adoption of the State Board's own organization and procedures including election of officers;

(2) Setting rules, regulations, standards, criteria, or plans implementing the provisions and purposes of the Act;

(3) Adoption of procedures for public notice and hearing on all proposed rules, regulations, standards, criteria, and plans required to carry out the provisions of the Act;

(4) Adopting criteria for recognition of areawide health planning organizations;

(5) Approval of certificates of recognition for areawide health planning organizations;

(6) Approval and authorization of the issuance of a permit for construction or modification of a health facility;

(7) Adoption of rules of procedure for review and appeal in case of denial of permit for construction or modification or for denial or revocation or certificate of recognition for areawide health planning organization;

(8) Scheduling an appeal fair hearing within 30 days after being notified a hearing is requested and appointing a hearing officer.

(9) Make its final determination following an appeal fair hearing;

(10) Issue subpoenas requiring the attendance and giving of testimony by witnessess and subpoenas duces tecum requiring the production of books, papers, records, or memoranda for an appeal fair hearing;

(11) Decide whether to require that the costs of service of subpoenas or subpoenas duces tecum issued at instance of any other party to such proceeding be borne by the party at whose instance the witness is summoned, and decide whether to require a deposit to cover the cost of such service and witness fees;

(12) Apply to any Circuit Court of this state to compel attendance of witnesses, production of books, papers, records, or memoranda and the giving of testimony before it or its hearing officer;

(13) May cause depositions of witnesses within the State to be taken in the manner prescribed by law for like depositions in civil actions in courts of this State, and to that end compel the attendance of witnesses and the production of books, papers, or memoranda;

(14) Order investigations to be made by the Agency in connection with an application for permit or application for a certificate or recognition.

(b) This Rule shall not contradict the State Board's statutory authority that (1) whenever the State Board finds that its decision on an application would be contrary to the finding of the recognized areawide health planning organization, the State Board shall, prior to making its decision on the permit, afford that organization an opportunity for a hearing before the State Board and (2) before the State Board

renders any negative decision relative to an application for a permit, a renewal therof, or an application for a certificate of recognition or a revocation therof, it shall notify the applicant or the holder of a permit or certificate and permit him and such other parties as the State Board permits to appear before the State Board and present such information as may be relevant to the approval of a permit or certificate or renewal therof or in resistance of the denial, revocation or modification of a permit or certificate.

1.12 Conflict of Interest

The State Board recognizes that a particular situation may present a conflict of interest as between any members' private interests and his or her service on the State Board. Such situations may arise where an application for a permit of a particular health care facility or an application for a certificate of recognition of an areawide health planning agency is filed by individuals, organizations or agencies with whom the member is closely associated or has a direct business relationship. In such instances the member shall declare the situation and refrain from voting on any matter relating to the particular situation. Membership in a provider association or service on its committees shall not be deemed a conflict of interest.

1.13 Renumeration and Reimbursement

State Board members, while serving on business of the State Board, shall receive actual and necessary travel and subsistence expenses while so serving away from their places of residence. In addition, while serving on business of the State Board which is authorized by the Chairman, each member shall receive compensation of $100 per day.

(1) Eligibility:

Voting members of the State Board shall be reimbursed through the State Agency for travel and subsistence expenses incurred in the performance of their duties as provided by law and/or by these Rules or Organization.

Ex-officio members of the State Board shall request reimbursement for travel and subsistence expenses from their respective departments as being a form of their official duties.

(2) Official Headquarters of Voting Members:

For the purpose of calculating travel and subsistence expenses of voting members of the State Board, the official headquarters of such members shall be their respective residences. Members are not entitled to reimbursement of living expenses while at their official headquarters.

(3) Official Travel Regulations:

Under ruling of the Attorney General, State of Illinois, dated April 21, 1972 (FILE NO. S-446), members of the State Board shall be subject to the restrictions of the TRAVEL REGULATIONS, State of Illinois, as amended, published by the Department of Finance and approved and promulgated by the Travel Control Board.

(4) Reimbursement Procedures:

All claims for reimbursement of travel and subsistence expenses shall be submitted on forms provided for the purpose. Submissions of such forms may be made subsequent to each meeting of the State Board, or may be held for submission at the conclusion of each month's individual activity. The Executive Secretary shall be the recipient of such vouchers for administrative processing and approval.

(5) Definition of Official Business Requiring Travel:

For the purpose of travel expense reimbursement, expenses incurred by the State Board members participating singly, or as a unit of the whole, or as a total State Board, shall be considered to be official business of the State and of the State Board when such expenses are incurred as a participant in the following activities:

(a) Regular and special State Board meetings called by the Chairman through the Executive Secretary.

(b) Participation in Investigations, hearings, judicial proceedings, or the like, in connection with a permit or an application for a certificate of recognition.

(c) Participation in public hearings relative to State Board Rules and/or health facilities standards, criteria, or plans.

(d) Participation in Task Forces, Ad Hoc Committees, and other special units prescribed by the Chairman of the State Board.

(e) Speaking before interested groups and organizations, as a representative of the State Board, for the purpose of describing the activities of the State Board, its procedures, and the laws governing its purpose, organization and operation.

(f) Attendance, as a representative of the State Board, at meetings conducted by agencies of the State and Federal governments, and by national, state and local organizations having a direct interest in health facilities planning, except that attendance at meetings held outside the state shall have the prior approval of the Chairman of the Board, the Executive Secretary, and the Department of Finance.

1.14 Rules of Order

Roberts Rules of Order shall govern the conduct of all meetings of the State Board, except that any matter on which the State Board is required by the Act to defer its action until parties have been notified and afforded the opportunity to appear before the State Board theron shall be deferred until the next meeting.

1.15 Official Headquarters

The Official Headquarters of the State Board shall be 525 West Jefferson, 5th Floor, Springfield, Illinois 62761.

1.16 Records and Reports

(a) The Executive Secretary shall be responsible for all records, reports and files of the State Board and shall keep same at the official headquarters.

(b) The Executive Secretary shall, on behalf of the State Board, make available for public inspection all rules adopted by the State Board in the discharge of its functions; all final orders, decisions and opinions of the State Board, except any such as are deemed confidential by state or federal statute; and shall maintain files available to the public containing all information declared public in this Act or in An Act in Relation to Meetings (Illinois Revised Statutes, Chapter 102, Sections 41-44) or in the Administrative Procedures Act, as amended, Chapter 127.

(c) All files created or received in the execution of the responsibilities under the Act shall be open to reasonable public inspection and copying at the offices of the State Board, State Agency, or certified areawide health planning organizations.

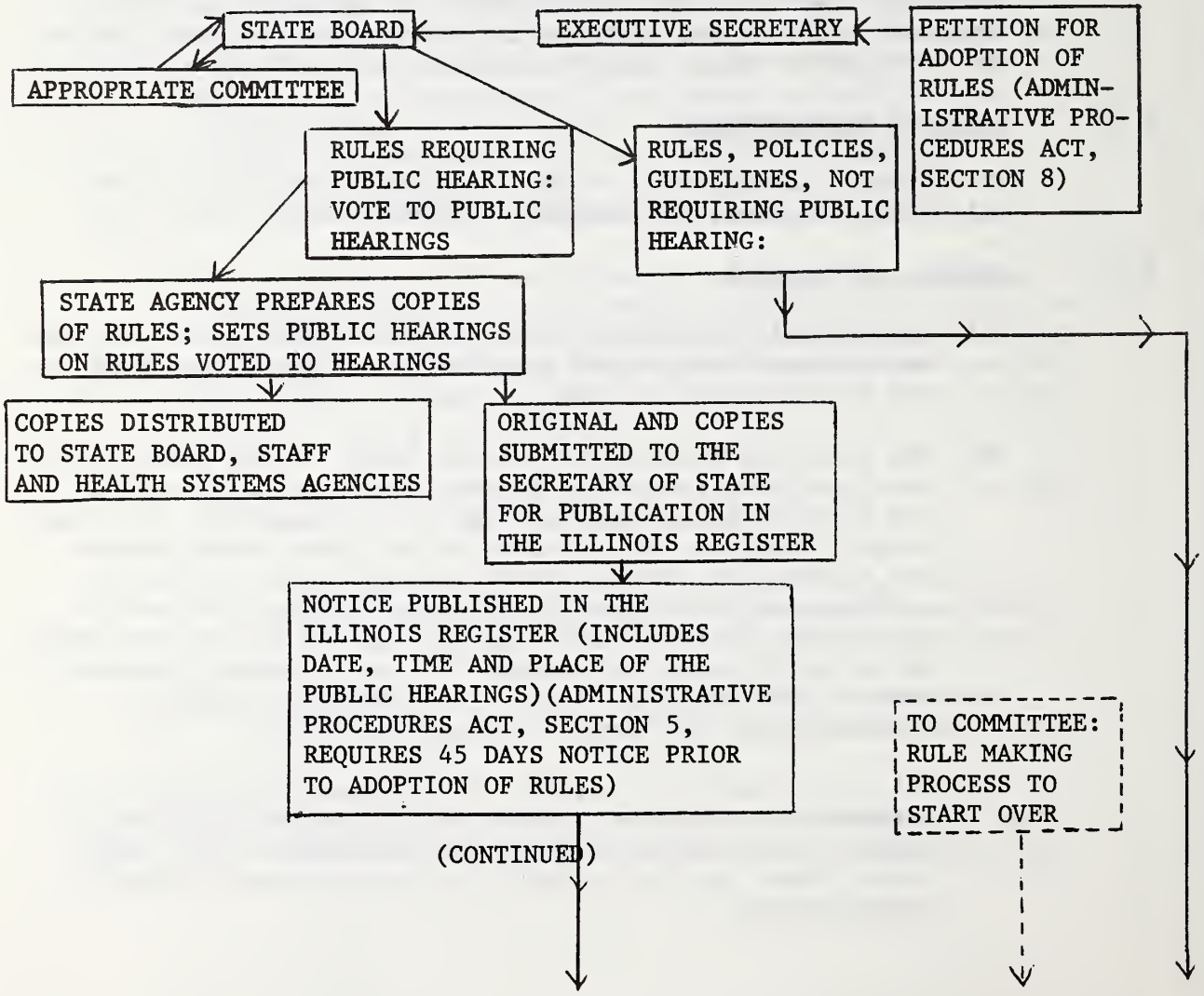
1.17 Amendment

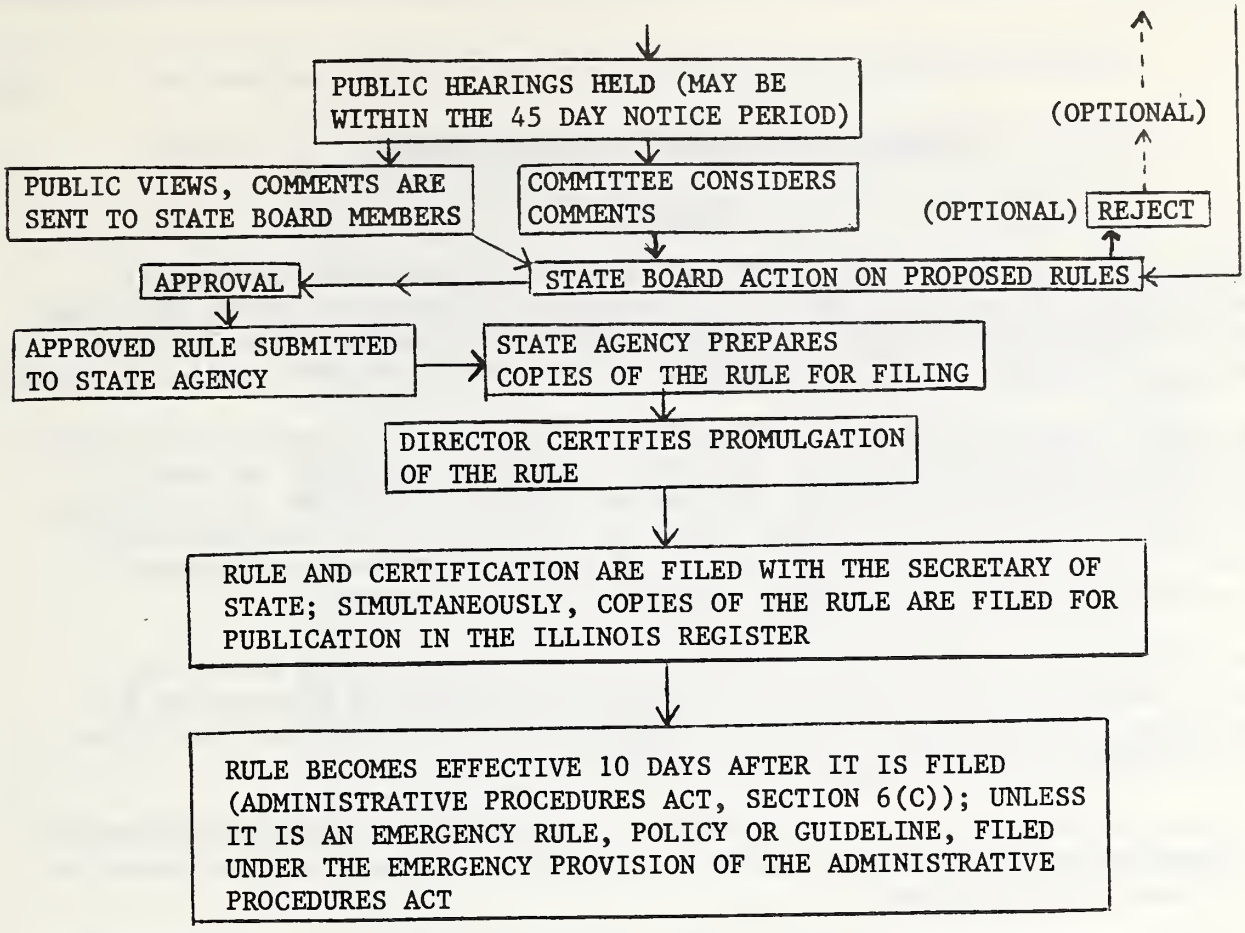
These Rules or Organization may be amended at any time by the affirmative vote of 7 or more voting members of the State Board--such amendment to be effectuated as provided by law.

1.18 Rule Making Procedure

(a) All proposed rules are referred by the State Board to the appropriate committee.

(b) Petitions for the adoption of rules (Administrative Procedures Act, Section 8) are submitted to the Executive Secretary. Any petitions submitted to the Department of Public Health shall be referred to the Executive Secretary for presentation to the State Board (See Rule 1, Section 1.10). Petitioners shall be notified of the disposition of their petition.




PUBLIC HEARINGS HELD (MAY BE WITHIN THE 45 DAY NOTICE PERIOD)
(OPTIONAL)
PUBLIC VIEWS, COMMENTS ARE SENT TO STATE BOARD MEMBERS
COMMITTEE CONSIDERS COMMENTS
(OPTIONAL) REJECT
APPROVAL
STATE BOARD ACTION ON PROPOSED RULES
APPROVED RULE SUBMITTED TO STATE AGENCY
STATE AGENCY PREPARES COPIES OF THE RULE FOR FILING
DIRECTOR CERTIFIES PROMULGATION OF THE RULE
RULE AND CERTIFICATION ARE FILED WITH THE SECRETARY OF STATE; SIMULTANEOUSLY, COPIES OF THE RULE ARE FILED FOR PUBLICATION IN THE ILLINOIS REGISTER
RULE BECOMES EFFECTIVE 10 DAYS AFTER IT IS FILED (ADMINISTRATIVE PROCEDURES ACT, SECTION 6(C)); UNLESS IT IS AN EMERGENCY RULE, POLICY OR GUIDELINE, FILED UNDER THE EMERGENCY PROVISION OF THE ADMINISTRATIVE PROCEDURES ACT

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

NOTICE

of the proposed revision to Rule 4.05.1 of the Illinois Health Facilities Planning Board, Rules For Processing Applications For Permit Filed By Hospitals, which was promulgated pursuant to Section 12 of the Illinois Health Facilities Planning Act (Chapter 111½, Paragraphs 1151-1167 of the Illinois Revised Statutes).

The proposed revision will alter the wording of Rule 4.05.1 (Section 4.05 of the Rules For Processing Applications For Permit Filed By Hospitals) in order to embody the arrangement arrived at between the Hospital Licensing Board and the Illinois Health Facilities Planning Board for coordination of the activities outlined. A complete text of the Section in which Rule 4.05.1 is located and a complete text of the proposed changes in wording follows.

On March 3, 1978, the Illinois Health Facilities Planning Board voted the proposed revision to Rule 4.05.1 of the Rules For Processing Application For Permit Filed By Hospitals to Public Hearings. Public Hearings on these Rules are scheduled for the following times, dates and locations:

2:00 p.m. on Tuesday, May 16, 1978, at the State of Illinois Department of Registration and Education Building, located at 55 East Jackson Street in Chicago, Illinois; and

6:30 p.m. on Wednesday, May 17, 1978, at the State of Illinois, Department of Transportation Building, located at 2300 South Dirksen Parkway in Springfield, Illinois.

Interested persons may appear at these Public Hearings and present either oral or written comments and views on this proposal(s). In addition, comments may be submitted in writing to George A. Lindsley, M.P.H., Executive Secretary of the Illinois Health Facilities Planning Board, Division of Planning and Conformance, Illinois Department of Public Health, 525 West Jefferson Street, Springfield, Illinois 62761, prior to May 16, 1978.

4.05 Coordination with the Hospital Licensing Act and Requirements.

4.05.1 It is the intent of the State Board that its procedures be appropriately coordinated, through the Secretary, with the procedures of the Department of Public Health and the Hospital Licensing Board in the administration of the Hospital Licensing Act and Requirements. The objective is to establish ~~a-management-system-under-the Secretary-for-a-single-flow-process-so-that-the-procedures and-requirements-of-the-two-programs-can-be-met-con-currently-in-an-orderly-and-timely-manner-with-a-minimum of-duplication,-delay-and-bureaucratic-red-tape.--To-this end,-the-Secretary-is-authorized,-among-other-things,-to establish-a-single-application-form-and-such-other-forms and-procedures-to-have-such-content-and-to-be-filed-in such-manner-as-will-enable-the-two-programs-to-meet-this objective.~~ a single process, meeting the requirements of both programs, with a minimum of duplication. To this end, the staffs of both Boards will cooperate in developing a single application form and other necessary forms and procedures, recommended to and approved by both Boards. The same intent and action to achieve coordination shall apply with respect to other related state health programs.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

NOTICE

of the proposed revisions to Section 4B.05 of the Illinois Health Facilities Planning Board, Rules For Processing Applications For Permit Filed By Long-Term Care Facilities, which was promulgated pursuant to Section 12 of the Illinois Health Facilities Planning Act (Chapter 111½, Paragraphs 1151-1167 of the Illinois Revised Statutes).

Rule 4B.05.2 will be revised to show the latest statutory amount of $150,000, rather than the amount of $100,000 currently shown. The proposed revisions to Section 4B.05 also include the inclusion of three new Rules: Rule 4B.05.8; 4B.05.9; and 4B.05.10. Proposed Rule 4B.05.8 deletes the "Rule 4B Exemption" as established in Rule 4B.05.05 as of the effective date that the proposed changes are filed with the Secretary of State as Rules. Proposed Rule 4B.05.9, voids exemptions granted under Rule 4B.05.7 unless actual on-site construction of the project has begun. Proposed Rule 4B.05.10 outlines procedure for revocation of exemptions granted under Rule 4B.05.7. A complete text of the entire Section 4B.05 showing a complete text of all proposed changes follows.

On March 3, 1978, the Illinois Health Facilities Planning Board voted the proposed revisions to Section 4B.05 of the Rules For Processing Applications For Permit Filed By Long-Term Care Facilities to Public Hearings. Public Hearings on these Rules are scheduled for the following times, dates and locations:

2:00 p.m. on Tuesday, May 16, 1978, at the State of Illinois, Department of Registration and Education Building, located at 55 East Jackson Street in Chicago, Illinois; and

6:30 p.m. on Wednesday, May 17, 1978, at the State of Illinois, Department of Transportation Building, located at 2300 South Dirksen Parkway in Springfield, Illinois.

Interested persons may appear at these Public Hearings and present either oral or written comments and views on these proposal(s). In addition, comments may be submitted in writing to George A. Lindsley, M.P.H., Executive Secretary of the Illinois Health Facilities Planning Board, Division of Planning and Conformance, Illinois Department of Public Health, 525 West Jefferson Street, Springfield, Illinois 62761, prior to May 16, 1978.

RULES FOR PROCESSING APPLICATIONS FOR PERMIT
FILED BY LONG-TERM CARE FACILITIES

4B.05 Applicability to particular construction or modification projects.

4B.05.1 An application for permit is required of all long-term care facility construction or modification projects for which construction contracts, purchase orders, leases and/or gift transactions or other methods of obligating a construction or modification or equipping project were not consumated prior to the effective date of the applicable standards, criteria or plans of the State Board, except such projects as are exempted in accordance with Section 5, paragraph 4 of the Act.

"Consumated", as used herein, means to have signed binding construction contracts, purchase orders, leases and/or gift or other transactions which are final and binding upon the parties.

4B.05.2 "Construction or modification" means, subject to the conditions of clauses (a), or (b), or (c) herein, the establishment, erection, building, alternation, reconstruction, modernization, improvements, extension, discontinuation, of a health care facility, or the purchase or acquisition of equipment of diagnostic or therapeutic purposes or for facility administration or operation, and for the purpose of clause (a) below the cost of the studies, surveys, designs, plans, working drawings, specifications, and other activities necessary thereto, which:

(a) requires a total capital expenditure in excess of ~~$100,000; or~~ $150,000; or

(b) substantially changes the scope or changes the functional operation of the facility; or

(c) substantially changes the bed capacity of a health care facility.

4B.05.3 "Construction contracts" shall mean the major binding contracts covering the principal work, including the general construction contracts, mechanical, electrical, plumbing and like contracts. For the purpose of Rule 4B.05.1, construction contracts, purchase orders, leases and/or gift transactions must be final and binding on the parties as evidenced by documents of proof acceptable to the State Board.

4B.05.4 Persons having construction or modification projects which are exempted under the provisions of Section 5, paragraph 4 of the Act, that is, that final plans and specifications for such work have, prior to October 1, 1974, been submitted to and approved by the requirements of applicable laws, shall comply with the requirements of Rule 2 of the State Board.

For purposes of determining the eligibility for exemption of long-term care facility construction or modification projects, Rule 2 shall be interpreted as though Section 2.03 of that Rule were deleted and as though the references to hospitals elsewhere in that Rule were references to long-term care facilities.

4B.05.5 Persons having construction or modification projects which are not exempted under Section 5, paragraph 4 of the Act, but who have, subsequent to October 1, 1974, and prior to the effective date of this Rule, obligated such projects by signing binding construction contracts, purchase orders, leases and/or gift transactions shall be exempt from the requirement of obtaining a permit for such project.

This shall be referred to as the "Rule 4B exemption" and shall apply only to the specific project of the same person and at the same site as was so obligated. Changes of site invalidate the exemption. Changes or modification made in such projects after the effective date

of this Rule, which changes or modifications would in themselves require a permit, are not exempted. The acquisition of land does not, by itself, obligate a project.

4B.05.6 To establish the exemption, the applicant shall notify the Executive Secretary and provide, therewith, the documentation of the pertinent facts. The person shall transmit the same information to the recognized areawide health planning organization concerned, which organization shall have the opportunity, within 5 working days, to notify the Executive Secretary of any comment or information it has relative to the entitlement to exemption. Documentation shall include a copy of final working drawings and specifications, and, for the Rule 4B exemption, shall include copies of the binding construction contracts, leases, purchase orders or gift transaction.

The Agency and the State Board shall have the right to request all documentation needed for evaluation of the applicant's entitlement to exemption and to exercise the powers conferred by the Act relevant to obtaining information.

4B.05.7 The Executive Secretary, acting on behalf of the State Board, shall make a determination of entitlement or non-entitlement to such exemption. The Executive Secretary will report the matter and the finding thereon to the State Board. Appeal of any party is to the Chairman of the State Board, who shall concur or non-concur in the determination made by the Executive Secretary.

4B.05.8 The "Rule 4B Exemption" established in Rule 4B.05.5 shall no longer be available as of the date this paragraph is filed with the Secretary of State as a rule.

4B.05.9 Exemptions granted under Rule 4B.05.7 shall be null and void as of the date this paragraph is filed with the Secretary of State as a rule unless actual on-site construction of the project for which such exemption was granted has begun

by such date. Each exempted project which is under construction must submit an estimated date of completion. Construction must continue with due diligence. For purposes of this paragraph, "on-site construction" means the permanent annexation, affixing or attachment of building materials or equipment to the site of the proposed project which building materials or equipment are a part of the exempted construction or modification project.

4B.05.10 The exemption granted under Rule 4B.05.7 may be revoked for the failure to continue construction with due diligence or for any reason which would have been as basis for declaring the exemption null and void under Rule 4B.05.09.

NOTICE BY THE ILLINOIS DEPARTMENT OF INSURANCE
REGARDING ADOPTION OF RULE 56.01
RELIGIOUS AND CHARITABLE RISK POOLING TRUSTS

NOTICE

The Department of Insurance on March 15, 1978 has adopted Rule 56.01 Religious and Charitable Risk Pooling Trusts pursuant to Section 6 of the Administrative Procedure Act (Ill. Rev. Stat., 1975, Ch. 127 1/2, para. 1006). Rule 56.01 implements the provisions of the Charitable Risk Pool Trust Act as created by Public Act 80-530 (Ill. Rev. Stat., 1975, Ch. 148, para. 200 et seq.).

Rule 56.01 was filed as a proposed rule on January 13, 1978 and was published in the Illinois Register on January 20, 1978. In accordance with the Notice accompanying proposed Rule 56.01, the Department of Insurance conducted a public hearing on February 3, 1978 in Room 1600, State of Illinois Building, 1600 North LaSalle Street, Chicago, Illinois. Additionally, the Department of Insurance received written comments from interested persons prior to and subsequent to the public hearing. All testimony and written comments were reviewed and evaluated by the Department of Insurance prior to adoption of Rule 56.01 in its present form.

The Rule as adopted establishes standards for approval, operation and administration of trusts authorized under the Act, by which such trusts may be approved by the Director of Insurance.

The Rule deals with the following subject matters; documents required to be filed with the trust instrument; residency requirements; financial and performance examinations; benefit schedules; standards of solicitation and advertising; authorized investments; filing of financial statements; provisions for liquidations; procedures for amending the trust instruments; pooling among several trusts; and requirements of trust administrators.

The complete text of Rule 56.01 as adopted and a revised table of contents to Departmental Rules and Regulations follows.

ILLINOIS DEPARTMENTAL REGULATIONS

Revised March 15, 1978

ARTICLE LVI
RELIGIOUS AND CHARITABLE RISK POOLING TRUSTS

Rule 56.01. (Religious and Charitable Risk Pooling Trusts).

Section 1. Authority and Scope.

This Rule is promulgated by the Director of Insurance pursuant to Section 20 of the Religious and Charitable Risk Pool Act (Ill. Rev. Stat., 1975, Ch. 148, para. 200 et seq.), hereinafter the Act, which empowers the Director to "make reasonable rules and regulations as may be necessary for the administration of the Act". The purpose of this Rule is to establish standards for the establishment, operation and administration of trusts authorized by the Act.

Section 2. Applications for Approval.

A. Any person filing a trust instrument for approval of the Director of insurance pursuant to the Act shall file duplicate originals containing the following:

1. the trust instrument together with all necessary exhibits.

2. a proposed benefit schedule, including the rating contribution formula and the obligations of each beneficiary.

3. detailed biographies of all initial trustees including educational experience, professional designations and criminal convictions; similar biographies shall be filed with the Director within 14 days of appointment for any trustees appointed after the filing of the trust instrument.

4. identification of independent CPA for auditing purposes and a copy of the letter of engagement.

5. a letter of transmittal which identifies an individual to whom all official notices, correspondence and complaints may be sent.

6. copies of the certificates of authorities of each of the proposed beneficiaries.

7. all solicitation and/or advertising materials.

B. The trust instrument shall be in writing and shall be executed and in addition to the requirements contained in the Act shall contain provisions addressing the following:

1. a requirement that the trust itself may not be effective until written approval is granted by the Director of Insurance.

2. a requirement that the administrators, principal office and all funds of the trust be located within Illinois, including a requirement that the funds of the trust shall be deposited only in a national or state bank with appropriate trust powers located in Illinois.

3. a requirement that all beneficiaries be residents of the State of Illinois or if domiciled in a state other than Illinois, be affiliated with an Illinois domiciled beneficiary by common ownership, religious affiliation, association membership or similar association if not created for the purpose of risk pooling or sharing.

4. a requirement that each beneficiary supply appropriate documentation evidencing exempt status in accordance with Section 501c(3) of the Internal Revenue Code of 1954 as amended to be included in the permanent records of the trust.

5. a requirement that the trust be audited yearly by an independent certified public accountant.

6. a requirement that all insurance policies or programs purchased by the trust be purchased only from insurance companies authorized to do business within the State of Illinois or from qualified surplus lines brokers.

7. a requirement that should liquidation of the trust be necessary, liquidation will be carried out in accordance with the provisions of the trust.

Section 3. Examinations.

All trusts established and approved pursuant to the Act shall be subject to financial and/or performance examinations conducted by the Director of Insurance as often as he shall deem necessary. The examinations shall be conducted in accordance with the provisions of Sections 132, 401, 402 and 403 of the Illinois Insurance Code. All books, records, correspondence and papers of each trust shall be available for examination at any time and shall be located within the State of Illinois.

Section 4. Benefit Schedules.

A. Each trust established and approved pursuant to the Act shall establish benefit schedules for each type of protection against the risk of financial loss available to each beneficiary. Each benefit schedule shall clearly indicate that evaluations of each request for payment shall be conducted in accordance with a standardized written procedure. Each beneficiary shall receive the appropriate benefit schedule together with any amendments or modifications made to those schedules.

B. All benefits payable in accordance with the benefit schedules shall be subject to all claims practice standards contained in the Illinois Insurance Code and any Rule promulgated thereunder. The trust administrator shall maintain a file for each payment request made by each beneficiary and the file shall contain all relevant documents necessary to clearly reconstruct all events surrounding the request for payment.

Section 5. Solicitation and Advertising.

Each trust approved pursuant to the Act shall solicit beneficiaries in accordance with the following standards:

A. No solicitation or advertising material may contain any indication that the trust program or benefit schedule is endorsed by the Illinois Department of Insurance.

B. The words, "insurance", "indemnity", "insurance trust", or any other similar words may not be used in any solicitation or advertising material to indicate that the trust is an insurance company or that benefits are being provided by an insurance company unless that is the case.

C. Each solicitator shall be a salaried employee of the trust or trust administrator and shall be subject to examination by the Director of Insurance.

Section 6. Investments.

Each trust approved pursuant to the Act shall invest its funds only in securities permitted by the law of this State for the investment of assets by insurance companies. All such investments shall be subject to valuation in accordance with Section 124.6 of the Illinois Insurance Code.

Section 7. Financial Statements.

Each trust approved pursuant to the Act shall file audited financial statements in accordance with the requirements of Section 14 of the Act containing the following information:

A. A balance sheet listing all assets and liabilities presented on an accrual basis which provides for an estimate of the ultimate net cost of all losses and related loss adjustment incurred as of the statement date.

B. A statement of income, expenses and fund balance.

C. A complete and detailed listing of each investment or asset held, such listing similar to the appropriate investment schedules contained in the Convention Annual Statement of the National Association of Insurance Commissioners for insurance companies.

D. A statement of Changes in Financial Position.

To the extent possible such financial statements shall be prepared in accordance with accounting principles permitted or prescribed for use by property and casualty insurance companies.

In addition, each trust shall file audited financial statements audited by an independent certified public accountant designated in the application required by Section 2 of this Rule. The auditing standards to be employed are those recommended by the American Institute of Certified Public Accountants. In addition to any other information the Director may from time to time require to be disclosed, the audited financial report shall include the following:

A. Report of independent certified public accountant.

B. Balance sheet reporting assets, liabilities and surplus fund.

C. Statement of gain or loss from operations.

D. Statement of Changes in Financial Position.

E. Notes to the financial statement essential for an adequate understanding of the trust and its financial statements.

Section 8. Liquidation.

Each trust is required to adhere to reasonable standards of financial solvency. Should the Director, within his discretion and based upon examination or investigation, determine that any trust is no longer adhering to reasonable standards of financial solvency, he may undertake appropriate proceedings in order to liquidate the trust entity.

Section 9. Amendments to the Trust Instrument.

A. All amendments or modifications to the originally approved trust instrument shall be made in writing and filed in duplicate with the Director of Insurance and approved by the Director of Insurance prior to their taking effect.

B. All trustees selected as successors to the original trustees set forth in the application required by Section 2 of this Rule shall submit complete biographical data to the Director of Insurance within 14 days of their appointment. This requirement may be satisfied by the filing of such data by the trust or trust administrator and shall be kept as a part of the permanent records of the trust.

Section 10. Pooling Among Several Trusts.

A. No trust established and approved pursuant to the provisions of this Act shall enter into any written agreements with any other trust fund for the pooling and sharing of risks unless such other trust funds have been established and approved pursuant to the provisions of this Act.

B. No trust established and approved pursuant to the provisions of this Act shall pool or share risks with any other trust established by the laws of any state of the United States other than Illinois. It is the specific intention of this provision to limit the pooling and sharing of risks among religious and charitable risk pooling trusts to trust funds approved pursuant to the Act and located in Illinois.

Section 11. Administrators.

A. Each trust approved pursuant to the Act may engage an administrator for the purpose of administrating and operating the trust fund. Such administrator shall be a resident of the State of Illinois with its principal office located within the State of Illinois. Such administrator may be a natural person, partnership or corporate entity.

B. All persons administering a trust approved pursuant to the provisions of the Act shall be subject to the examination of the Director of Insurance in accordance with Section 132 of the Illinois Insurance Code and shall maintain all trust records within the State of Illinois.

C. All administrators of trusts approved pursuant to the provisions of the Act must adhere to all standards of fiduciary conduct required by the laws of the State of Illinois and must adhere to all standards of claims practices and procedures set forth in the Illinois Insurance Code and all Rules promulgated thereunder.

Section 12. Severability.

If any provision of this Rule or the application thereof to any person or circumstance is held invalid, the invalidity shall not effect other provisions or applications of this Act which can be given affect without the invalid provision or application, and to this end the provisions of the Rule are severable.

Section 13. Effective Date.

This Rule shall be effective on the 26th day of March, 1978.

(Adopted 3/16/78)

NOTICE BY THE ILLINOIS RACING BOARD

OF THE PROPOSED REPEAL OF

RULES REGARDING BIG "Q" AND BIG "P" WAGERING

NOTICE

The Illinois Racing Board, pursuant to the statutory authority contained in Section 9(b) of the Illinois Horse Racing Act of 1975, (Ill. Rev. Stat., Ch. 8, Sec. 37-9(b)), proposes to repeal the rules regarding Big "Q" and Big "P" wagering. These wagers have not been permitted in Illinois for several years.

The full text of the rules to be repealed is set forth hereinafter.

For ease of reference, the Rules and Regulations of Horse Racing are referred to hereinafter as "Thoroughbred Rules." The Rules and Regulations of Harness Racing are referred to hereinafter as "Harness Rules." Except for differences in numbering, these Harness and Thoroughbred Rules are identical.

All interested persons are invited to submit their views concerning the proposed action by filing written comments with the Secretary of the Board at the following address:

Illinois Racing Board
160 N. La Salle St.
Chicago, Illinois 60601

Comments may be filed either in person or by mail. All comments must be filed within 30 days of the date of publication of this issue of the ILLINOIS REGISTER.

~~Harness Rule 26.21 Conducting Big "Q" Wagering -~~
~~Thoroughbred Rule 454 Conducting Big "Q" Wagering -~~

~~Each operator wishing to conduct Big "Q" wagering must first petition the board for permission to do so.~~

~~A. Each operator shall either print in the daily program or prominently post at all areas where Big Q wagering is conducted the complete rules for Big Q wagering as set forth in the following sections.~~

~~B. The Big Q consists of selecting the Quinella (the first two horses to finish) of each of two consecutive races. Pari-mutuel wagering tickets are to be sold upon the first race of the two races only. The division of the pool shall be calculated as in a straight pool, subject to provisions of these rules to the contrary.~~

~~C. No entries or field horses shall be allowed to start in any race comprising the Big Q.~~

~~D. Tickets shall be sold only at Big Q windows and only from automatic double issuing machines.~~

~~E. Each bettor purchasing tickets shall designate his two selections as the first two horses to finish in the first race of the two races.~~

~~F. After the official declaration of the first two horses to finish the first of the Big Q races, each bettor holding a ticket combining the said two horses to finish must, prior to the running of the second race, exchange such winning ticket for a Big Q exchange ticket at the Big Q windows and at such time the said holder shall select the first two horses to finish in the second race of the Big Q. No further money shall be required of the holders of the ticket in order to make the exchange.~~

~~G. No Big Q exchange ticket upon the second race shall be issued except upon the surrender of the Big Q ticket from the first race as described in these sections. The Big Q pool obtained from the sales of Big Q tickets upon the first race shall be held subject to these sections, and divided among the winning tickets of the Big Q exchange tickets, subject to these sections to the contrary. Big Q windows shall be open for the purpose of making the exchange as described only after the first race has been declared official and such windows shall close at post time at the start of the second race of the Big Q races.~~

H.--If a winning Big Q ticket from the first race is not presented for exchange within the time provided, the bettor forfeits all rights to any distribution or refund except in the event the second half of the Big Q is cancelled or declared "no race" or if no exchange ticket includes either the first or second horse of the second half of the Big Q.

Harness Rule 26.22 Scratches -
Thoroughbred Rule 455 Scratches -

If a horse is scratched in the first race, all Big Q tickets on the scratched horse will be refunded.

A.--If a horse is scratched in the second race, the holders of tickets on the scratched horse will be entitled to exchange their tickets for another selection. In the event of a late scratch, after the exchange windows have been closed, all exchange tickets combining the scratched horse shall become consolation tickets and shall be paid a price per dollar denomination calculated as follows:--the net Big Q pool (gross pool less commission) shall be divided by the total purchase price of all tickets combining the winnings of the first race of the Big Q.--The quotient thus obtained shall be the price to be paid to holders of exchange tickets combining the scratched horse in the second race of the Big Q.--The entire consolation pool (number of eligible tickets times the consolation price) plus the breakage shall be deducted from the net Big Q pool.

Harness Rule 26.23 Winning Combinations -
Thoroughbred Rule 456 Winning Combinations -

If no ticket is sold as a winning combination in the first race of the Big Q, the Big Q pool shall be divided among those having tickets including the horse finishing first or second and such distributions shall be calculated and made as a place pool.--In such an instance, the Big Q race shall end and the pool be closed for the day.

A.--If no Big Q exchange ticket is sold on the winning combination, the net pool shall be apportioned equally between those having tickets including the horse finishing second in the same manner in which a place pool is calculated and distributed.

B.--If a Big Q exchange ticket combines only one of the winners and no Big Q exchange ticket combines the other winner, the entire pool shall be distributed as a straight pool to the holders of those tickets.

C.--If no exchange ticket includes either the first or second horse of the second half of the Big Q, the entire net pool will be distributed as a straight pool to all holders of exchange tickets and winning combinations of the first half that have not been exchanged.

Harness Rule 26.24 Dead Heats -
Thoroughbred Rule 457 Dead Heats -

In the event of a dead heat for place in the first race of the Big Q races, all Big Q tickets combining the first horse and either of the place horses shall be eligible for exchange for Big Q exchange tickets.

A.--In the event of a dead heat for place in the second race of the Big Q races, the pool will be divided, calculated and distributed as a place pool to the holders of Big Q exchange tickets combining the first horse and either of the place horses.--In the event of the dead heat to place and there are no tickets sold on one combination, then the other combination having winning horses shall be declared the winner.

B.--If no exchange tickets combine the winning horse with either of the place horses in the dead heat, the Big Q pool shall be calculated and distributed as a place pool to holders of tickets combining either of the place horses; however, if any exchange tickets combine both horses in the dead heat for place, the Big Q pool shall be calculated and distributed as a place pool to holders of such tickets.

Harness Rule 26.25 Races Not Run -
Thoroughbred Rule 458 Races Not Run -

If for any reason the first race of the Big Q race is cancelled or declared "no race" full and complete refund shall be made from the Big Q pool.

A.--If for any reason, the second of the Big Q races is cancelled or declared "no race" the pool shall be calculated as a straight pool and shall be distributed among the holders of tickets combining the first two horses of the first race of the Big Q otherwise eligible for Big Q exchange tickets and also distributed to holders of the Big Q exchange tickets.

B.--If there is a dead heat for the winning horses in either of the two consecutive races for the Big Q such calculation of distribution of the Big Q pool

shall be made in the manner in which any ordinary Quinella pool would be made should there be a dead heat for the win despite the number of horses involved in the dead heat.

Harness Rule 26.26
Thoroughbred Rule 459 Incorrect Tickets -

In the event that an incorrect exchange ticket is issued during the second half of the Big Q pool, such incorrect exchange ticket must be turned into the State Auditor prior to the running of the second half. Said tickets shall be deducted from both exchange and individual combination totals. The ticket shall be voided and filed with the performance worksheets and a report, including the seller's name and license number, shall be made to the board of the complete incident.

Harness Rule 26.27 Big "P" Rules -
Thoroughbred Rule 460 Big "P" Rules -

The Big P consists of selecting two horses that will finish first and second in each of two consecutive races in the exact order as officially posted.

A. Big P tickets shall be sold only at Big P windows by the operator and only from automatic double issue machines.

Harness Rule 26.27B

Each bettor purchasing Big P tickets shall designate his two selections as the first two horses to finish in that order in the first race of the two consecutive races.

Thoroughbred Rule 461 General Big P Rules -

Each bettor purchasing Big P tickets shall designate his two selections as the first two horses to finish in that order in the first race of the two consecutive races.

Harness Rule 26.27C -
Thoroughbred Rule 461A

After the official declaration of the first two horses to finish in the first race of the Big P, each bettor holding a ticket combining the first two horses in the exact order of finish must, prior to the running of the second Big P race, exchange such winning ticket for a Big P exchange ticket at the Big P windows and at such time shall select the two horses to finish in the second

race in the exact order as officially posted. No further money shall be required of the holder of the tickets in order to make the exchange.

Harness Rule 26.27D
Thoroughbred Rule 462 Exchange Tickets -

No Big P exchange ticket upon the second race shall be issued except upon the surrender of the Big P ticket from the first race as described in these rules. The Big P pool obtained from the sales of Big P tickets upon the first race shall be held, subject to these rules, and divided among the winning tickets of the Big P exchange tickets. Big P windows shall be open for the purpose of making the exchange as described only after the first race has been declared official and such windows shall close at official post time at the start of the second race of the Big P races.

Harness Rule 26.27E
Thoroughbred Rule 463 Unexchanged First Race Tickets -

If a winning Big P ticket from the first race is not presented for exchange within the time provided, the bettor forfeits all rights to any distribution or refund except in the event the second half of the Big P is cancelled or declared "no race" or if no exchange ticket includes either the first or second horse of the second half of the Big P.

Harness Rule 26.28 Scratches -
Thoroughbred Rule 464 Scratches -

If a horse is scratched in the first race, all Big P tickets on the scratched horse will be refunded.

A. If a horse is scratched in the second race, the holders of tickets on the scratched horse will be entitled to exchange their tickets for another selection.

B. In the event of a late scratch after the exchange windows have been closed, all exchange tickets combining the scratched horse shall become consolation tickets and shall be paid a price per dollar denomination calculated as follows: the net Big P (gross pool less takeout, divided by the total purchase price of all tickets combining the winners of the first race.) The quotient thus obtained shall be the price to be paid to holders of exchange tickets combining the scratched horse in the second race. The entire consolation pool (number of eligible tickets times the consolation price) plus the breakage shall be deducted from the net Big P pool.

~~Harness Rule 26.29 Pool Divisions -~~
~~Thoroughbred Rule 465 Pool Divisions -~~

~~If no ticket is sold as a winning combination in the first race, the Big P pool shall be divided among those having tickets including the horse finishing first or second and such distributions shall be calculated and made as a place pool. In such an instance, the Big P race shall end and the pool be closed for the day.~~

~~A. If no Big P exchange ticket is sold on the winning combination, the net pool shall then be apportioned equally between those having tickets including the horse finishing first and those having tickets including the horse finishing second in the same manner in which a place pool is calculated and distributed.~~

~~B. If a Big P exchange ticket combines only one of the two winners and no Big P exchange ticket combines the other winner, the entire pool shall be distributed as a straight pool to the holders of those tickets.~~

Illinois Department of Children and Family Services
Notice of Proposed Rulemaking
Regulation 5.22, Criminal History Checks of Foster Family Home Applicants

NOTICE

The Department of Children and Family Services proposes to adopt new rules and regulations entitled "Criminal History Checks of Foster Family Home Applicants," promulgated in accordance with Illinois Revised Statutes, chapter 23, section 2214 (1977).

The purpose of these rules is to provide procedures and safeguards for the Department to access and review criminal history record information in the licensing process for foster parents.

TIME, PLACE AND MANNER
IN WHICH ALL PERSONS MAY PRESENT
THEIR VIEWS CONCERNING THE PROPOSED RULES

Interested persons wishing to present their views concerning this intended action may do so by sending written comments to the attention of:

Thomas Felder, Chief of Licensing Enforcement
Illinois Department of Children and Family Services
One North Old State Capitol Plaza
Springfield, Illinois 62706

The Department shall consider all written comments reviewed by the Department within 45 days from the date of publication of this Notice.

The full text of the proposed rule follows:

Illinois Department of Children and Family Services Regulation 5.22, Criminal History Checks of Foster Family Home Applicants

In exercise of its statutory grant of authority to conduct criminal history checks of foster parent applicants, the Department of Children and Family Services shall require each and every applicant for a foster home license, whether applying directly to the Department or through a licensed Child Welfare Agency, to provide written authorization for the Department of Children and Family Services to request and receive criminal history information concerning said applicant from any Federal, State, or Local law enforcement agency.

Each applicant for a foster home license shall submit to a fingerprinting process administered by the Department or its agent. Said fingerprints shall constitute the only identity material to be transmitted to the Illinois Department of Law Enforcement or other law enforcement agency by the Department of Children and Family Services for the purpose of obtaining any criminal history information concerning a foster parent applicant.

Any and all information received by the Department of Children and Family Services from a law enforcement agency which pertains to an applicant for foster home licensure shall be deemed confidential and may be released only as authorized by this Regulation. All information received pursuant to this Regulation shall be maintained in a single manual information system under the unitary control of the Department of Children and Family Services' Chief of Licensing Services. There shall be no duplication in any manner of the identity materials submitted by the foster parent applicant. All criminal history information shall be used solely for the purpose of evaluating an applicant's suitability as a foster parent and shall be accessible only to those Department of Children and Family Services' employees directly involved in the foster home licensing process for that specific applicant. Any employee of the Department of Children and Family Services who gives or causes to be given, in a manner not authorized by this Regulation, any criminal history information concerning a foster parent applicant shall be guilty of a Class A misdemeanor pursuant to Sec. 4 of the Child Care Act of 1969, amended 1977.

In assessing the suitability of an applicant for foster parent licensure, the Department may consider only that criminal history information which documents a conviction for a criminal offense or the existence of a criminal charge pending at the time of application. The standard of review of a foster parent applicant who has a criminal history shall be the relationship between the offense which was the basis for the conviction and the applicant's ability to perform responsibly as a foster parent. Strict scrutiny shall be

employed in the evaluation of an applicant who has been convicted of any offense involving children, or any use of force, or participation in any socially or sexually deviant activities.

A finding that criminal charges were pending against an applicant at the time the application for foster home licensure was filed shall suspend the application process for that particular individual until some disposition of the charge is submitted to the Department.

Any decision of denial or refusal to renew a license based on the findings of the criminal history check shall be executed in writing by the Chief of Licensing Services after full review of the licensing study and consultation with the Licensing Representative responsible for the case, and shall include the specific reasons for such decision. This written statement shall be supplied to the applicant, together with notice of his/her right to appeal the decision.

All criminal history information obtained by the Department shall be destroyed not later than 60 days after the Department has made a final unappealed ruling on the application or at such time as all rights of appeal have been exhausted by the applicant.

Each applicant for foster home licensure shall be informed in writing of the Department's requirement that the applicant consent to a criminal history check and submit to fingerprinting procedures as part of the foster home licensing process. Applicants shall also be informed of their right to recover the identity material submitted and to receive a copy of all criminal history information obtained by the Department.

After the criminal history check has been completed, all identity materials obtained from the applicant by the Department of Children and Family Services, or its agent, shall be returned to the applicant upon written request to the Department of Children and Family Services, in its original form, with no copies made or retained by the Department of Children and Family Services, or any agency to which such identity materials were transmitted.

All information obtained from the criminal history check, including the source of the information, and any conclusions or recommendations derived from this information by the Department of Children and Family Services, shall be provided to the applicant, or his/her designee, upon written request to the Department, prior to any final action by the Department of Children and Family Services on the application.

The applicant may request, in writing, review by the Director of a decision to deny or refuse to renew a foster home license within 10 days from the applicant's receipt of notice that such decision was made. A request for directoral review shall be based on the applicant's challenge to

the reasonableness of the decision. The applicant's failure to request an appeal within this 10 day period shall render the denial or refusal to renew a license a final administrative ruling, subject only to administrative review in the Circuit Court.

ILLINOIS DEPARTMENT OF PUBLIC AID
NOTICE OF PROPOSED AMENDMENT
TO THE RULE ON GROUP CARE SERVICES

IDPA Rule 4.14 incorporates in Attachment II the rates the Department will pay for group care services. Pursuant to authority granted in Chapter 23, Sections 5-7 and 12-13, Illinois Revised Statutes, the Department proposes to amend Rule 4.14 by revising rate schedules for ICF/MR payments. These revisions are being proposed pursuant to Federal statutory and regulatory requirements that mandated revisions in the Department's system for reimbursing skilled nursing and intermediate care facilities. These changes must be implemented, effective for services delivered on or after January 1, 1978. The prior notice of this proposed rulemaking, which appeared in the Illinois Register on January 27, 1978, is hereby withdrawn and replaced by this notice.

Pursuant to Sections 5(b) and 6 of "The Illinois Administrative Procedure Act", the Department has adopted the proposed rule as an Emergency Rule effective January 13, 1978.

Within 14 days of the date of publication of this notice, any interested person may request the opportunity to submit comments, data, views or arguments regarding this proposal. The request and submittals must be in writing and should be addressed to Jeffrey C. Miller, Medical Assistance Program Administrator, Illinois Department of Public Aid, 316 South Second Street, Springfield, Illinois 62762. The Department will consider all written submittals made pursuant to such requests if the submittals are received within 35 days of the date of publication of this notice.

A complete text of the proposed Rule follows, which indicates the amended portions. Obsolete pages are designated "OBSOLETE" and the obsolete rate schedules are crossed out with an "X". Pages with the new rate schedules are designated "NEW".

RULE 4.14 GROUP CARE SERVICES

General Provisions:

Payment to facilities licensed by the Department of Public Health approved and certified for participation and qualified shall be made to provide medical group care services to public assistance recipients. These facilities include skilled nursing homes (SNF), intermediate care facilities (ICF), intermediate care facilities for mentally retarded (ICF/MR), skilled nursing homes for pediatrics (SNF/PED) and state operated group care facilities.

Initial and continuing need for group care must be established by the Department in cooperation with the recipient, the physician and the family.

Prior approval is a requirement for admission of a recipient to a group care facility.

Challenges of the decision with respect to the determination of the rate of payment or the type of care required for the individual recipient shall be initiated by the recipient or the administrator of the group care facility. The Department will provide the criteria used in determining the type of care required by the recipient.

Management of Recipient Funds

Facilities that maintain a recipient's personal funds must have the recipient's written request. Facilities are required to establish a separate identifiable bank account (individual or group) and a written record of that account. A written

RULE 4.14 GROUP CARE SERVICES (Cont.)

record of the account must be provided to each recipient at least quarterly. Accrued interest on funds must be credited to the recipient's account whether the funds are in an individual or group account.

Recipient funds are not to be spent for items which the facility is required to provide or to improve the real or personal property of the facility. Facilities are required to furnish the Department records of each recipient's personal funds upon request. Advising and counseling the recipient regarding the use of the personal allowance is the responsibility of the Department.

Bed Reserve

Bed reserve for hospitalized recipients will be allowed only when a physician indicates the recipient will be released to the same facility; that it would be traumatic to the patient not to return to the same facility and when there is a shortage of beds within the community. Payment may be approved for a total period not to exceed ten days.

Therapeutic home visits will be allowed where the physician indicates it is therapeutically beneficial to the recipient. Payment may be approved for a total period not to exceed eighteen days during the calendar year. In ICF/MR facilities payment may be approved when ordered by the physician for a period not to exceed seven consecutive days, or ten days per calendar month. With prior approval by the Department, home visits may be extended.

The facility is required to obtain prior approval for all bed holds. Payment for approved bed hold is at a daily rate of two percent of the current monthly rate approved for the recipient.

RULE 4.14 GROUP CARE SERVICES (Cont.)

Basis of Payment

The amount approved for payment for group care is based on the type and amount of services required by and actually being furnished to a recipient and is determined in accordance with the Department rate schedule. The approved Department rate cannot exceed the charges to non-recipients.

A rate exceeding the rate schedule may be approved by the Department for a period not to exceed 60 days, if necessary to affect hospital discharge. Costs not related to patient care, as well as costs in excess of those required for the efficient and economical delivery of care, will not be reimbursed. Examples of non-allowable costs are:

1) Any service not related to direct nursing care such as day care, other out-patient care, non-patient meals, and non-patient laundry.

2) Any revenue producing amenities such as the gift and coffee shop, barber and beauty shop, and television and radio in the resident's room.

3) Any services which the Department pays for separately such as laboratory, radiology, and dental services.

4) Cost of items sold to patients or non-patients and the cost of any non-group care restricted drugs.

5) Any expenses incurred by the owner or owning corporation which are not nursing care related. Such expenses include the following:

RULE 4.14 GROUP CARE SERVICES (Cont.)

a) Non-working officer's salary
b) Compensation to non-working owners
c) Non-care related interest
d) Non-care related owner's transaction
e) Personal expenses of owner
f) Non-care related fees
g) Training program for non-employees
h) Fines and penalties
i) Entertainment
j) Contributions
k) Owner of key-man life insurance
l) Special legal fees
m) Non-care related patient transportation
n) Malpractice insurance for individuals
o) Director's fees
p) Non-patient related transportation and travel
q) Bad debts

6) Owners compensation in excess of compensation in comparable situations.

7) Non-straight line depreciation or depreciation in excess of Medicare guidelines

8) Unnecessary interest expense as determined by Health Insurance Manual 15 guidelines.

9) Expenses incurred in transactions with related organizations above the cost of the organization providing those services

RULE 4.14 GROUP CARE SERVICES (Cont.)

as specified in Unitied States Department of Health Education and Welfare, Medicare Provider Reimbursement Manual: Health Insurance Manual, Social Security Administration 1974.

Allowable costs of purchases of any item or services from a related organization is restricted to the actual cost of providing the service or the price of comparable service purchased elswhere, whichever is less. All related organizations doing business with the facility, and the specific transactions must be indentified on the cost report.

Facilities are required to submit cost reports annually. Reports must be submited on uniform cost report forms prescribed by the Department. The completion of cost reports must be by the accural method of accounting. Facilities are required to retain sufficient records to support and verify the cost reports for a minimum of three years following submission of the cost report and to make such information available to both State and Federal staff upon request.

The amount approved for payment of group care is based on three components:

Support costs (administration, dietary, housekeeping, laundry, utilities);

Nursing costs (rehabilitative nursing, social rehabilitation, activity program);

Capital costs (comprising rent or ownership costs).

The Department reimburses for support costs at actual costs up to the 50th percentile of all skilled and intermediate facilities in the

RULE 4.14 GROUP CARE SERVICES (Cont.)

Health Service Area (HSA) including those with no medicaid patients. A facility experiencing support costs at less than the 50th percentile shall be allowed to retain one-half the difference between actual updated support costs and the group ceiling.

The Department reimburses for nursing costs based on geographic area in which the facility is based, the level of care the facility (or distant part thereof) is licensed to provide, and the total point count determined by an evaluation of a recipient's need. Attachment 1 to this rule provides the guidelines on which the point count evaluation is made. Attachment 2 provides the rates paid per point of skilled and intermediate care facilities.

The Department reimburses for capital costs on a group basis related to location and base year. A base year is defined as follows:

1) For facilities built or purchased prior to July 1, 1977, the later of year of construction or year of purchase;

2) For facilities built July 1, 1977, or later, the year of construction;

3) For facilities purchased on or after July 1, 1977, the base year established under (1) above will not change.

The average statewide capital expense for each year is calculated and adjusted for cost differences within geographic areas and the resultant amount is paid to all facilities regardless of actual capital costs. Attachment 3 is a map showing the geographic regions used in determining allowable capital costs. Costs will be reviewed annually with new rates being established for each calendar year.

RULE 4.14 GROUP CARE SERVICES (Cont.)

Cost adjustments will be made on a minimum occupancy standard. Facilities having utlization levels below the standard will have their per patient day cost adjusted as if occupancy were at the standard.

a) For capital cost a standard of 93 percent occupancy or actual, whichever is larger, is used. Ninety-three percent is the median occupancy for the State.

b) For operating costs (support and nursing) a standard of actual or one-third of the difference between the actual occupancy and 93 percent, if the occupancy rate is below 93 percent.

On-site audits will be made to verify the accuracy and reasonableness of reported costs.

Any non-exempt income or contributions available to or received by the recipient or the facility from any source on behalf of the recipient must be deducted in determining the amount of payment authorized by the Department.

All facilities providing group care are to provide at no additional charge:

- All the staff, equipment and supplies, including oxygen, required to provide the services needed by the recipients accepted for care by the facility.

- Room and board, supervision and oversight, and laundry services.

- Food substitues and supplements.

RULE 4.14 GROUP CARE SERVICES (Cont.)

- Medications which are regularly available without prescription at a commercial pharmacy and which may be stocked by the facility under the Department of Public Health regulations.

Utilization Control

The Department or its designee conducts medical review and utilization review to maintain quality assurance for recipients of group care.

Medical Reviews for Skilled Nursing Facilities and Institutions for Mental Diseases and Independent Professional Reviews for Intermediate Care Facilities are required annual reviews to evaluate:

1) Care being provided persons receiving assistance under a state plan;

2) adequacy of services available in a particular facility;

3) necessity and desirability of continued placement in a particular facility; and

4) feasibility of an alternative solution to continued stay in a particular facility.

Utilization Reviews for Intermediate Care Facilities are required semi-annual reviews also evaluate the above listed items. The Independent Professional Review may serve as one of the Utilization Reviews.

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I

ICF/MR POINT COUNT GUIDELINES

ICF/MR Guidelines are to be used in Intermediate Care Facilities for the Mentally Retarded (ICF/MR) by the Departments of Public Aid (DPA) and Mental Health and Developmental Disabilities (DMHDD). DMHDD will certify each individual as an ICF/MR client. DPA will then apply these guidelines to each individual certified as an ICF/MR client by DMHDD to evaluate need for care and to determine point count assessment for payment. Points are given, in each area of service listed within the guidelines, on the basis of the highest level of services "required" and received by a client during the evaluation period.

The certification of need for care as an ICF/MR client is to be based on current diagnostic material and clinical judgment. Once a determination is made and a client is certified as an ICF/MR client, the evaluation for point count assessment is to be based on the results of the DMHDD certification/recertification, consultation with, or written orders from the physician, personal observation of the client, and the facility's record of services provided. In some instances DPA casework staff is required to refer cases to the Regional Medical Assistance Consultant before allowing points. Regional Consultants are free to contact Regional Public Health Nurses, Department of Mental Health staff, or other professional medical or nursing personnel for consultation as needed.

Before applying the ICF/MR Point Count Guidelines, a few symbols, words, and word phrases must be defined. For additional convenience, the defined words and word phrases are then italicized wherever they are used in the Guidelines.

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I(2)

. A single plus (+) in the criteria indicates special program needs for an ICF/MR client. The client must exhibit a need for at least one of these programs to be eligible for ICF/MR certification and recertification.

. A double plus (++) in the criteria indicates that special approval is necessary. A written specialized program must first be submitted to the Regional DD Coordinator for recommendations. The program and recommendations shall then be forwarded to the Division of Developmental Disabilities for consideration of approval or disapproval. Upon approval the Division shall, in writing, notify the Region/Subregion office of the point assessment. Notification of Division approval shall also be made in writing to the Region/Subregion. DMHDD will notify the lcoal DPA office of the point assessment and effective date of the Specialized Program.

. A Structured Learning and Maintenance Program is a systematic attempt to bring about behavioral changes which will maximize the client's ability to function independently. The structured learning program component concerns itself with skill acquisition; the maintenance component concerns itself with the continued performance of a skill once it has been acquired. The structured learning and maintenance program must:

a. Be consistent with the

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I(3)

"facility's general program plan," as submitted to the Department of Mental Health and Developmental Disabilities.

b) Be supervised and conducted by "appropriate staff" as designated in the Minimum Rules and Regulations for ICF/DD.

c) Include, in written forms in the individual client's record, clearly "defined goals" which detail the desired behavorial outcome.

d) Include, in wirtten form in the individual client's record, a "systematic plan" for achieving those goals.

e) Include documentation which indicates the "frequency" of the client's participation in program sessions.

Unstructured Assistance involves staff interaction with the clinet which attempts to bring about behavioral change, but which lacks one or more of the elements required in a structured learning and maintenance program. To qualify under this definition, the staff interaction must meet at least requirements a. and b. of the definitions of a structured learning and maintenance program.

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I (4)

. A client may be said to be independent in a given skill if he performs that skill under contingencies similar to those that prevail in the "normal" community.

. Maintenance is a systematic attempt to encourage the continued performance of a skill.

. A client may be said to require a program if it is determined to the satisfaction of the facility's inderdisciplinary team that he is not independent in a particular skill, and further, that it is indeed desirable for him to acquire that skill.

1) Physical and/or Occupational Therapy

0 - Client neither requires nor receives physical therapy and/or occupational therapy.

8 - Client requires and is receiving physical therapy and/or occupational therapy services supervised by professional therapy staff.

2) Medication

0 - Client neither requires nor receives prescribed medication, or the client's condition is such that the physician gives written permission for the resident to handle the medication himself.

2 - Client requires and receives prescribed medication administered by staff.

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I (5)

+5 - Client requires and receives precribed medication which is administered by staff, but the client is also involved in a structured learning and maintenance program directed toward independence in the self-administration of prescribed medication.

3) Special Diet

0 - Client neither requires nor receives a special diet which varies from the menu used for the majority of clients in the facility, with or without minor modifications, such as removal of salt or sugar on trays, substitution of salads or desserts, etc. This includes pureed and baby food, or a mechanical (ground) diet.

3 - Client requires and receives a special diet prescribed by the attending physician and which must be prepared separately from the daily menu. This includes salt free, weighed, or calculated caloric diets, and diets and tube feeding which require the purchase of special foods.

4. Dressings

0 - Client neither requires nor receives dressings or additional care because of case, etc., or client requires only an occasional small temporary dressing for minor cuts or abrasions.

2 - Client requires and receives application of dressings or additional care because of a case, and/or assistance with the application of appliances such as prostheses, braces, and supports.

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I (6)

5) Maladaptive Behavior

0 - Client neither requires nor receives assistance in controlling maladaptive behavior. He can be reasoned with and can adjust his behavior. On the whole, his behavior is consistantly cooperative. He does not require any special supervision.

+3 - Client requires and receives unstructured assistance in controlling identified maladaptive behavior.

+8 - Client requires and is involved in a structured learning and maintenance program directed toward controlling maladaptive behavior.

6) Social Habilitation and Activities

Social Habilitation and Activities include, but are not limited to the following programs: toileting, bathing, oral hygiene, grooming, dressing and/or undressing, personal possessions, eating, social skills, money management skills, and activities.

0 - Client neither requires nor receives assistance in social habilitation and activities.

+3 - Client requires and receives unstructured assistance in social habilitation and activities which are supervised by professional habilitation staff.

+5 - Client requres and is involved in a structured learning and maintenance program directed in social habilitation

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I (7)

and activities which are supervised by professional and habilitation staff.

7) Transportation

0 - Client neither requires nor receives assistance directed toward independent use of public or non-public transportation.

+3 - Client requires and is involved in a structured learning and maintenance program directed toward independent use of public and non-public transportation.

8) Speech and Hearing

0 - Client neither requires nor receives assistance, or client is independent in speech and hearing skills.

+4 - Client requires and receives unstructured assistance directed toward independence in speech and hearing skills.

+6 - Client requires and is involved in a structured learning and maintenance program, directed toward independence in speech and hearing skills.

9) Equipment

0 - Client neither requires nor receives individualized, adaptive equipment.

+3 - Client requires and receives individualized adaptive equipment as part of a structured learning and maintenance program directed toward independence in the use of this equipment.

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I (8)

10) Specialized Program++

+1-8 Program and points may be approved for clients requiring a specialized program for which specific provision has not been made above. (This point assessment must be reevaluated quarterly.)

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I (9)

MEDICAL SERVICE PROVISIONS (continued)

EVALUATION OF NEED FOR CARE AND POINT COUNT ASSIGNMENT

The following guidelines are to be used by Department staff to determine point allowances and evaluate the need for care in group care facilities. Points are given, in each area of service listed below, on the basis of the highest level of services required and received by a recipient during the evaluation period. Points are allowed only for services provided by staff of the facility unless otherwise specified, as in the two point allowance in item 11. Points are not allowed for services recipients perform themselves or for services performed by individuals not employed by the facility, except where otherwise specified for individual items.

The evaluation is to be based on consultation with or written orders from the physician, personal observation of the recipient, and the facilities' record of services porvided. In some instances casework staff are required to refer cases to the Regional Medical Assistance Consultant before allowing points or determining placement. Regional consultants are free to contact Regional Public Health Nurses, Department of Mental Health staff, or other professional medical or nursing personnel for consultation as needed.

A pound sign (#) in the criteria identifies services which require care in a skilled nursing facility. In addition, a recipient having a

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I(10)

total point count of 25 points or more, on a continuing basis, requires skilled care. An asterisk (*) identifies services which require care in an intermediate care facility. Services not identified by either a pound sign or an asterisk may be provided in sheltered care facilities. Before authorizing care in a group care facility, an evaluation of other, more suitable, arrangements for care must be investigated. Care in a group care facility is to be approved only when there is no appropriate alternative.

1) Eating

0 - No point is allowed when the recipient is able to eat independently.

1 - One point is allowed when the recipient requires assistance in cutting food, buttering bread, placing utensils for blind recipient, etc.

2 - Two points are allowed when the recipient requires and receives some individual assistance in eating from a staff member. The assistance may vary from complete feeding on some days to partial feeding on others. Also included here is the type of assistance which can be given by a staff member to more than one patient in the same room during the meal.

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I(11)

MEDICAL SERVICE PROVISIONS (continued)

4 - Four points are allowed when the recipient requires and receives complete individual attention by a staff member at all meals. The staff member remains in constant attendance at the patient's side throughout mealtime to hand feed the recipient or to insure adequate intake of food.

#8 - Eight points are allowed when the recipient is unable to take food by mount and tube feeding or gastrostomy feeding are given by licensed nurses on the physician's orders.

2) Mobility

0 - No point is allowed when the recipient is independent in movement with or without assistive devices and no assistance is needed to enable him to move from place to place. This includes the recipient who is able to transfer himself to and from a wheelchair.

*2 - Two points are allowed when the recipient is able to move about but needs a staff member to assist him to get into a wheelchair, to begin walking with the walker; or to walk beside him to give assistance, etc.

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I(12)

May be allowed in a sheltered care facility for a recipient who can move about independently but needs assistance to get into a wheelchair or begin walking with a walker if 1) the facility is determined safe for the resident by IDPH, 2) the resident's quarters are on the first floor, and 3) access to the facility is at grade level or ramps are provided. Prior approval is required from the Regional Medical Assistance Consultant who will verify safety with IDPH.

*3 - Three points are allowed when the recipient is unable to move about under his own power. He must be moved by a staff member. This may consist of pushing the wheelchair or lifting the patient. This also includes the recipient who is able to move except that his size or other physical condition reuqires that more than one nursing staff member be at his side to give assistance in moving about.

3) Behavior or Mental Condition

0 - No point is allowed for the recipient who is usually able to act in a manner that takes into account his needs and the needs of others and staff. He can be reasoned with and can adjust his behavior. On the whole, his behavior is consistantly cooperative. He is aware of who he is and what is expected of him within the home. He does not require any special supervision.

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I(13)

MEDICAL SERVICE PROVISIONS (continued)

3 - Three points are allowed for the recipient who requires occasional supervision from a staff member. He presents problems such as periods of hyperactivity or confusion, occasional strong reactions to frustrations or disappointments, prolonged periods of silence, excessive pacing or sleeping, or inability or unwillingness to interact. During such "ups and downs" he requires temporary support and vigilance from the staff.

*8 - Eight points are allowed for the recipient who requires special and continuous supervision by a licensed nurse. His tolerance is so low and unpredictable that a licensed nurse must be present in the facility at all times.

4) Current Physical Rehabilitation Needs

Rehabilitation nursing consists of services ordered by a physician, such as range of motion exercises, positioning, transfer activities, gait training, parallel bars, pulleys, and training of the aphasic. Bowel and bladder training programs are not included. The acute illnesses and injuries for which 8 or 12 points may be given include fractures of hip, pelvis, and extremities; acute brain trauma (to include spinal cord injuries or neurological disorders, but not to include congenital brain disorders); cerebral vascular accidents with resulting aphasia and/or hemiplegia; amputees requiring pre- and post- prosthetic care and training.

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I(14)

0 - No point is allowed for the recipient who does not require rehabilitation or who has no potential for rehabilitation.

*4 - Four points are allowed for the recipient who needs and is receiving rehabilitation nursing services, performed or supervised by a licensed nurse, to maintain current level of function.

4a) Habilitation services consist of services ordered by a physician which are designed to help the individual obtain the highest possible level of functioning. These services may include, but are not limited to, neuro-developmental techniques and sensory motor training. Conditions for which 12 points may be given include physical and mental disabilities or handicaps which are birth-related, congenital or resulting from acute illnesses or injury and which can be expected to continue indefinetely. The 12 points provided for under this item may not be authorized if points under item 4 have been authorized. Items 4 and 4a are mutually exclusive.

*12 - Twelve points are allowed for a recipient who needs and is receiving habilitation and nursing services supervised by professional habilitation staff because of the conditions described above, if the facility has an approved rehabilitation nursing program.

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I(15)

NOTE: Payment for the services described above are to be authorized only for children under age 18 residing in approved Division 18 group care facilities.

Twelve points are allowed for a recipient who needs and is receiving intensive rehabilitation nursing services supervised by a licensed nurse following selected acute illnesses or injuries within a period of three months following discharge from a hospital or rehabilitation facility.

5) Catheterization (including irrigations)

0 - No point is allowed when the recipient does not require catheterization or irrigation.

*4 - Four points are allowed when the recipient requires an occasional catheterization for a specimen or treatment, or an indwelling catheter for a short term physical condition.

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I(16)

*8 - Eight points are allowed when the physician orders a retention catheter to be used continuously. This also includes full care of the catheter and irrigations.

When a retention catheter is used the patient shall not be considered to be requiring or receiving care because of bladder incontinence under item 6, even though in some instances the patient may be on a bowel and bladder training program for a short period while the catheter is used.

6) Incontinence (Bladder and Bowel)

0 - No point is allowed when the recipient has complete bladder and bowel control.

1 - One point is allowed when recipient usually has control except on those infrequent occasions when he has an accident due to nervousness or visitors, on reaction to medications, such as cathartics.

2 - Two points are allowed when recipient is neither continent nor incontinent; sometimes he has control; other times he has none.

*6 - Six points are allowed when the recipient has no bladder and/or bowel control and he requires care for cleanliness or comfort. This includes the patient who dribbles constantly.

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I(17)

*8 - Eight points are allowed when the recipient has in the past had no control but is now receiving training through an active bowel and bladder program. The physician has ordered such a program and the nursing care plan for the patient includes this program (maximum length of time -- initial period three months; if successful an additional three months; maximum total six months).

*8 - Eight points are allowed for a recipient who needs and is receiving services to maintain bowel and bladder control following a bowel and bladder training program.

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I(18)

7) Douches, Enemas and/or Colostomy Irrigations

0 - No point is allowed when recipient does not require douches, enemas or colostomy irrigations, or requires and receives such service at infrequent intervals for the treatment of a short-term condition.

*4 - Four points are allowed when the recipient requires and receives a douche, enema and/or colostomy irrigation on a regular basis but less than daily.

*5 - Five points are allowed when the recipient requires and receives a douche, enema and/or colostomy irrigation at least daily.

When enemas are required and given on a regular baiss, the patient is not considered, under item 6, to have bowel incontinence.

8) Diet

0 - No point is allowed when the diet ordered by the physician is the menu used for the majority of the patients in the facility, with or

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I(19)

without minor modifications, such as removal of salt or sugar on trays, substitution of salads or desserts, etc. This includes pureed and baby food, or a mechanical (ground) diet.

*3 - Three points are allowed when the diet ordered by the attending physician is a specific diet which must be prepared separately from the daily menu. This includes salt free, weighed or calculated caloric diets, and diets and tube feedings which require the purchase of special foods.

9) Medications (Oral, Drops, Ointments, Suppositories)

If a need for sheltered care is being considered the caseworker will determine whether the recipient is capable of handling his own medication, based on the physician's order, caseworker's knowledge of the recipient, and his past behavior pattern. The attending physician's order regarding the recipient's ability to selfadminister medications will be the determining factor in deciding whether a recipient can handle his own medications. In instances where a recipient is taking more than two prescribed medications and is residing in a sheltered care facility, or is being considered for referral to a sheltered care facility, and the physician's order for self administration does not list all medications being taken, a listing of all medications prescribed for that individual is to be forwarded to the Regional Medical Assistance Consultant. A brief

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I(20)

statement of the recipient's condition, including diagnosis, and the caseworker's recommendation regarding the recipient's capability of handling his own medication is to accompany the list of medications. The Regional Medical Assistant Consultant will review the information and advise the county department in those cases where additional contact with the physician is recommended.

Precribed PRN and variable dosage medications, controlled substances, and anticoagulants cannot be self-administered in a sheltered care facility.

0 - No point is allowed when medication is not prescribed, or the recipient's condition is such that the physician gives written permission for the resident to handle the medication himself. This includes supervised self-administration in sheltered care facilities.

*1 - One point is allowed for the recipient who requires and receives prescribed medication (oral, drops, ointments, suppositories) administered by staff on a less than daily basis.

*3 - Three points are allowed for the recipient who requires and receives prescribed medication (oral, drops, ointments, suppositories) administered by staff on a <u>regular daily basis</u>.

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I(21)

10) Injections (Hypodermic and Intramuscular)

0 - No point is allowed when hypodermics or intramuscular injections have not been prescribed by the physician or when a recipient is permitted to self-administer a drug by hypodermic on the written order of the physician.

*2 - Two points are allowed when hypodermics and/or intramuscular injections are administered on a less than daily basis by a licensed nurse.

*4 - Four points are allowed when the recipient requires and receives a daily injection of medication by a licensed nurse throughout the evaluation period.

11) Intravenous and Subcutaneous Fluids

0 - No point is allowed when the recipient does not require intravenous or subcataneous fluids.

*2 - Two points are allowed when the recipient requires and receives intravenous and/or subcutaneous medication or fluids administered by the physician. (This allowance compensates the facility for supplies used.)

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I(22)

#8 - Eight points are allowed when intravenous or subcutaneous fluids are administered by a registered professional nurse upon the physician's order.

12) Suctioning

0 - No point is allowed when the recipient does not require suctioning.

*3 - Three points are allowed when a recipient has a condition, such as a tracheotomy, to which he has become adjusted to such a degree that he is able to care for it himself with minimum assistance by nursing staff for cleansing purposes.

*5 - Five points are allowed when the recipient requires suctioning less than daily.

#8 - Eight points are allowed when the recipient requires suctioning daily throughout the evaluation period.

13) Oxygen (Includes Positive Pressure)

0 - No point is allowed when the recipient has no need for oxygen services.

*4 - Four points are allowed when the recipient requires oxygen on an emergency basis or intermittently during the month. Also included is the recipient who is able to administer his own oxygen and/or positive pressure treatments with supervision and minimum assistance.

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I(23)

#8 - Eight points are allowed when there is a current written order, and the recipient receives oxygen and/or positive pressure treatments on a daily basis, administered by nursing staff.

14) Dressings and Appliances

0 - No point is allowed when the recipient requires no dressings or requires only an occasional small temporary dressing for minor cuts or abrasions.

*4 - Four points are allowed when the recipient requires daily application of Ace bandages, additional care because of a case and/or assistance with the application of appliances such as prostheses, braces and supports.

*6 - Six points are allowed when the recipient requires dressings to a moderate sized area and/or moist dressings or soaks, on a continuing basis. Such services may be required for, but are not limited to: decubiti; recurrent leg ulcers; and daily colostomy dressings.

#8 - Eight points are allowed when there is a physician's written order for comprehensive dressings required on a regular daily basis, performed by a R.N. or graduate L.P.N.

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I(24)

15) Intermediate Care

* - If services listed above do not indicate a need for either skilled or intermediate care, but the recipient needs services which must be provided or supervised by licenses nursing personnel, then intermediate care is required. When the need for such a servise is identified by the caseworker or is pointed out by either the attending physician or facility staff and the caseworker verifies the need, a notation of the service which requires the licensed nursing personnel is to be made on the evaluation form and intermediate care is to be authorized. If the caseworker questions the need for licensed nursing personnel, the caseworker will refer the case to the Regional Medical Assistance Consultant for a determination of the level of care required. If intermediate care is approved a notation of the service which requires the licensed nursing personnel is to be made on the authorization form.

16) Skilled Care

\# - If services listed above do not indicate a need for skilled care but the recipient needs 24 hour licensed nursing care or supervision to meet specific needs indicated in his plan for care or an R.N. is required to assess the patient's needs and prepare the plan for care or a plan for the

RULE 4.14 GROUP CARE SERVICES (cont.)
ATTACHMENT I(25)

administration and/or control of medications such as narcotics or dicumerol, skilled care is required. When the need for such a service is identified by the caseworker or pointed out by the attending physician or facility staff, and the caseworker verifies the need, a notation of the service requiring skilled care is to be made on the evaluation form and skilled care is to be authorized. If the caseworker questions the need for skilled care, the caseworker will refer the case to the Regional Medical Assistance Consultant for a determination of the level of care required. If skilled care is approved a notation of the service requiring skilled care is to be made on the evaluation form.

17) Assistance with bathing: YES __ NO __

18) Assistance with dressing: YES __ NO __

19) Assistance with grooming: YES __ NO __

RULE 4.14 GROUP CARE SERVICES (CONT.)

ATTACHMENT II

HEALTH SERVICE AREAS (HSAs)

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II(2)

INTERMEDIATE CARE FACILITY (ICF) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) I

The Counties included in HSA I are:

Boone	Dekalb	Lee	Stephenson	Winnebago
Carroll	Jo Daviess	Ogle	Whiteside	

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	3.02	84.56	90.60	93.62
2	3.25	91.00	97.50	100.75
3	3.48	97.44	104.40	107.88
4	3.71	103.88	111.30	115.01
5	3.93	110.04	117.90	121.83
6	4.16	116.48	124.80	128.96
7	4.39	122.92	131.70	136.09
8	4.62	129.36	138.60	143.22
9	4.85	135.80	145.50	150.35
10	5.07	141.96	152.10	157.17
11	5.30	148.40	159.00	164.30
12	5.53	154.84	165.90	171.43
13	5.76	161.28	172.80	178.56
14	5.99	167.72	179.70	185.69
15	6.21	173.88	186.30	192.51
16	6.44	180.32	193.20	199.64
17	6.67	186.76	200.10	206.77
18	6.87	192.36	206.10	212.97
19	7.05	197.68	211.80	218.85
20	7.25	203.00	217.50	224.75
21	7.44	208.32	223.20	230.64
22	7.63	213.64	228.90	236.53
23	7.82	218.96	234.60	242.42
24	8.01	224.28	240.30	248.31

(Add .191 to the daily rate for each point over 24)

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II(3)

SKILLED NURSING FACILITY (SNF) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) I

The Counties included in HSA I are:

Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	4.81	134.68	144.30	149.11
2	5.04	141.12	151.20	156.24
3	5.27	147.56	158.10	163.37
4	5.50	154.00	165.00	170.50
5	5.73	160.44	171.90	177.63
6	5.95	166.60	178.50	184.45
7	6.18	173.04	185.40	191.58
8	6.41	179.48	192.30	198.71
9	6.64	185.92	199.20	205.84
10	6.87	192.36	206.10	212.97
11	7.09	198.52	212.70	219.79
12	7.32	204.96	219.60	226.92
13	7.55	211.40	226.50	234.05
14	7.78	217.84	233.40	241.18
15	8.01	224.28	240.30	248.31
16	8.23	230.44	246.90	255.13
17	8.45	236.88	253.80	262.26
18	8.66	242.48	259.80	268.46
19	8.85	247.80	265.50	274.35
20	9.04	253.12	271.20	280.24
21	9.23	258.44	276.90	286.13
22	9.42	263.76	282.60	292.02
23	9.61	269.08	288.30	297.91
24	9.80	274.40	294.00	303.80
25	9.99	279.72	299.70	309.69
26	10.18	285.04	305.40	315.55
27	10.37	290.36	311.10	321.47
28	10.55	295.68	316.80	327.35
29	10.75	301.00	322.50	333.25
30	10.94	306.32	328.20	339.14
31	11.13	311.64	333.90	345.03
32	11.32	316.96	339.60	350.92
33	11.51	322.28	345.30	356.81
34	11.70	327.60	351.00	362.70
35	11.89	332.92	356.70	368.59
36	12.08	338.24	362.40	374.48
37	12.27	343.56	368.10	380.37
38	12.46	348.88	373.80	386.26
39	12.65	354.20	379.50	392.15
40	12.84	359.52	385.20	398.04
41	13.03	364.84	390.90	403.93
42	13.22	370.16	396.60	409.82
43	13.41	375.48	402.30	415.71
44	13.60	380.80	408.00	421.60
45	13.79	386.12	413.70	427.49
46	13.98	391.44	419.40	433.38
47	14.17	396.76	425.10	439.27
48	14.36	402.08	430.80	445.16
49	14.55	407.40	436.50	451.05
50	14.74	412.72	442.20	456.94

(Add .191 to the daily rate for each point over 50)

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II(4)

INTERMEDIATE CARE FACILITY (ICF) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) II

The counties included in HSA II are:

Bureau	Knox	McDonough	Stark	Woodford
Fulton	LaSalle	Peoria	Tazewell	
Henderson	Marshall	Putnam	Warren	

Points	Daily Rates	Monthly Rates		
		28 Days	30 Days	31 Days
1	3.09	86.52	92.70	95.79
2	3.32	92.96	99.60	102.92
3	3.55	99.40	106.50	110.05
4	3.79	106.12	113.70	117.49
5	4.02	112.56	120.60	124.62
6	4.25	119.00	127.50	131.75
7	4.49	125.72	134.70	139.19
8	4.72	132.16	141.60	146.32
9	4.95	138.60	148.50	153.45
10	5.19	145.32	155.70	160.89
11	5.42	151.76	162.60	168.02
12	5.65	158.20	169.50	175.15
13	5.83	164.64	176.40	182.28
14	6.12	171.36	183.60	189.72
15	6.35	177.80	190.50	196.85
16	6.53	184.24	197.40	203.98
17	6.82	190.96	204.60	211.42
18	7.03	196.84	210.90	217.93
19	7.22	202.16	216.60	223.82
20	7.41	207.48	222.30	229.71
21	7.61	213.08	228.30	235.91
22	7.80	218.40	234.00	241.80
23	8.00	224.00	240.00	248.00
24	8.19	229.32	245.70	253.89

(Add 195 to the daily rate for each point over 24)

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II(5)

SKILLED NURSING FACILITY (SNF) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) II

The Counties included in HSA II are:

Bureau, Fulton, Henderson, Knox, LaSalle, Marshall, McDonough, Peoria, Putnum, Stark, Tazewell, Warren, Woodford

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	4.92	137.76	147.60	152.52
2	5.15	144.20	154.50	159.65
3	5.39	150.92	161.70	167.09
4	5.62	157.36	168.60	174.22
5	5.85	163.80	175.50	181.35
6	6.09	170.52	182.70	188.79
7	6.32	176.96	189.60	195.92
8	6.55	183.40	196.50	203.05
9	6.78	189.84	203.40	210.18
10	7.02	196.56	210.60	217.62
11	7.25	203.00	217.50	224.75
12	7.48	209.44	224.40	231.88
13	7.72	216.16	231.60	239.32
14	7.95	222.60	238.50	246.45
15	8.18	229.04	245.40	253.58
16	8.42	235.76	252.60	261.02
17	8.65	242.20	259.50	268.15
18	8.88	248.64	265.90	274.68
19	9.05	253.40	271.50	280.55
20	9.25	259.00	277.50	286.75
21	9.44	264.32	283.20	292.64
22	9.63	269.64	288.90	298.53
23	9.83	275.24	294.90	304.73
24	10.02	280.56	300.60	310.62
25	10.22	286.16	306.60	316.82
26	10.41	291.48	312.30	322.71
27	10.60	296.80	318.00	328.60
28	10.80	302.40	324.00	334.80
29	10.99	307.72	329.70	340.69
30	11.19	313.32	335.70	346.89
31	11.38	318.64	341.40	352.78
32	11.57	323.96	347.10	358.67
33	11.77	329.56	353.10	364.87
34	11.96	334.88	358.80	370.76
35	12.16	340.48	364.80	376.96
36	12.35	345.80	370.50	382.85
37	12.54	351.12	376.20	388.74
38	12.74	356.72	382.20	394.94
39	12.93	362.04	387.90	400.83
40	13.13	367.64	393.90	407.03
41	13.32	372.96	399.60	412.92
42	13.51	378.28	405.30	418.81
43	13.71	383.88	411.30	425.01
44	13.90	389.20	417.00	430.90
45	14.10	394.80	423.00	437.10
46	14.29	400.12	428.70	442.99
47	14.48	405.44	434.40	448.88
48	14.68	411.04	440.40	455.08
49	14.87	416.36	446.10	460.97
50	15.07	421.96	452.10	467.17

(Add .195 to the daily rate for each point over 50)

RULE 4.14 GROUP CARE SERVICES (CONT.)

ATTACHMENT II(6)

INTERMEDIATE CARE FACILITY (ICF) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) III

The Counties included in HSA III are:

Adams	Christian	Logan	Montgomery	Schuyler
Brown	Greene	Macoupin	Morgan	Scott
Calhoun	Hancock	Mason	Pike	
Cass	Jersery	Menard	Sangamon	

Points	Daily Rates	Monthly Rates		
		28 Days	30 Days	31 Days
1	3.08	86.24	92.40	95.48
2	3.31	92.68	99.30	102.51
3	3.54	99.12	106.20	109.74
4	3.78	105.84	113.40	117.18
5	4.01	112.28	120.30	124.31
6	4.24	118.72	127.20	131.44
7	4.48	125.44	134.40	138.88
8	4.71	131.88	141.30	146.01
9	4.94	138.32	148.20	153.14
10	5.17	144.76	155.10	160.27
11	5.41	151.48	162.30	167.71
12	5.64	157.92	169.20	174.84
13	5.87	164.36	176.10	181.97
14	6.11	171.08	183.30	189.41
15	6.34	177.52	190.20	196.54
16	6.57	183.96	197.10	203.67
17	6.81	190.68	204.30	211.11
18	7.00	196.00	210.00	217.00
19	7.19	201.32	215.70	222.89
20	7.39	206.92	221.70	229.09
21	7.58	212.24	227.40	234.98
22	7.78	217.84	233.40	241.18
23	7.97	223.16	239.10	247.07
24	8.16	228.48	244.80	252.96

(Add .194 to the daily rate for each point over 24)

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II(7)

SKILLED NURSING FACILITY (SNF) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) III

The Counties included in HSA III are:

Adams	Christian	Logan	Montgomery	Schuyler
Brown	Greene	Macoupin	Morgan	Scott
Calhoun	Hancock	Mason	Pike	
Cass	Jersey	Menard	Sangamon	

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	4.90	137.20	147.00	151.90
2	5.14	143.92	154.20	159.34
3	5.37	150.36	161.10	166.47
4	5.60	156.80	168.00	173.60
5	5.83	163.24	174.90	180.73
6	6.07	169.96	182.10	188.17
7	6.30	176.40	189.00	195.30
8	6.53	182.84	195.90	202.43
9	6.77	189.56	203.10	209.87
10	7.00	196.00	210.00	217.00
11	7.23	202.44	216.90	224.13
12	7.47	209.16	224.10	231.57
13	7.70	215.53	231.00	238.70
14	7.93	222.04	237.90	245.83
15	8.16	228.48	244.80	252.96
16	8.40	235.20	252.00	260.40
17	8.63	241.64	258.90	267.53
18	8.82	246.96	264.60	273.42
19	9.02	252.56	270.60	279.62
20	9.21	257.88	276.30	285.51
21	9.41	263.48	282.30	291.71
22	9.60	268.80	288.00	297.60
23	9.79	274.12	293.70	303.49
24	9.99	279.72	299.70	309.69
25	10.18	285.04	305.40	315.58
26	10.38	290.64	311.40	321.78
27	10.57	295.96	317.10	327.67
28	10.76	301.28	322.80	333.56
29	10.95	306.88	328.80	339.75
30	11.15	312.20	334.50	345.65
31	11.35	317.80	340.50	351.85
32	11.54	323.12	346.20	357.74
33	11.73	328.44	351.90	363.63
34	11.93	334.04	357.90	369.83
35	12.12	339.36	363.60	375.72
36	12.32	344.96	369.60	381.92
37	12.51	350.28	375.30	387.81
38	12.70	355.60	381.00	393.70
39	12.93	361.20	387.00	399.90
40	13.09	366.52	392.70	406.79
41	13.29	372.12	398.70	411.99
42	13.48	377.44	404.40	417.88
43	13.67	382.76	410.10	423.77
44	13.87	388.36	416.10	429.97
45	14.06	393.68	421.80	435.86
46	14.26	399.28	427.80	442.06
47	14.45	404.60	433.50	447.95
48	14.64	409.92	439.20	453.84
49	14.84	415.52	445.20	460.04
50	15.03	420.84	450.90	465.93

(Add .194 to the daily rate for each point over 50)

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II(8)

INTERMEDIATE CARE FACILITY (ICF) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) IV

The Counties included in HSA IV are:

Champaign	DeWitt	Ford	Macon	Piatt
Clark	Douglas	Iroquois	McLean	Shelby
Coles	Edgar	Livingston	Moultrie	Vermilion
Cumberland				

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	3.08	86.24	92.40	95.48
2	3.32	92.96	99.60	102.92
3	3.55	99.40	106.50	110.05
4	3.78	105.84	113.40	117.18
5	4.02	112.56	120.60	124.62
6	4.25	119.00	127.50	131.75
7	4.48	125.44	134.40	138.88
8	4.71	131.88	141.30	146.01
9	4.95	138.60	148.50	153.45
10	5.18	145.04	155.40	160.58
11	5.41	151.48	162.30	167.71
12	5.65	158.20	169.50	175.15
13	5.88	164.64	176.40	182.28
14	6.11	171.08	183.30	189.41
15	6.35	177.80	190.50	196.85
16	6.58	184.24	197.40	203.98
17	6.81	190.68	204.30	211.11
18	7.01	196.28	210.30	217.31
19	7.21	201.88	216.30	223.51
20	7.40	207.20	222.00	229.40
21	7.60	212.80	228.00	235.60
22	7.79	218.12	233.70	241.49
23	7.98	223.44	239.40	247.38
24	8.18	229.04	245.40	253.58

(Add .195 to the daily rate for each point over 24)

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II(9)

SKILLED NURSING FACILITY (SNF) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) IV

The Counties included in HSA IV are:

Champaign	DeWitt	Ford	Macon	Piatt
Clark	Douglas	Iroquois	McLean	Shelby
Coles	Edgar	Livingston	Moultrie	Vermilion
Cumberland				

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	4.91	137.48	147.30	152.21
2	5.14	143.92	154.20	159.34
3	5.38	150.64	161.40	166.78
4	5.61	157.08	168.30	173.91
5	5.84	163.52	175.20	181.04
6	6.09	170.24	182.40	188.48
7	6.31	176.68	189.30	195.61
8	6.54	183.12	196.20	202.74
9	6.78	189.84	203.40	210.18
10	7.01	196.28	210.30	217.31
11	7.24	202.72	217.20	224.44
12	7.47	209.16	224.10	231.57
13	7.71	215.88	231.30	239.01
14	7.94	222.32	238.20	246.14
15	8.17	228.76	245.10	253.27
16	8.41	235.48	252.30	260.71
17	8.64	241.92	259.20	267.84
18	8.84	247.52	265.20	274.04
19	9.04	253.12	271.20	280.24
20	9.23	258.44	276.90	286.13
21	9.42	263.76	282.60	292.02
22	9.62	269.36	288.60	298.22
23	9.81	274.68	294.30	304.11
24	10.01	280.28	300.30	310.31
25	10.20	285.60	306.00	316.20
26	10.29	288.12	308.70	319.09
27	10.59	296.52	317.70	328.29
28	10.78	301.84	323.40	334.18
29	10.98	307.44	329.40	340.38
30	11.17	312.76	335.10	346.27
31	11.36	318.08	340.80	352.16
32	11.56	323.68	346.80	358.36
33	11.75	329.00	352.50	364.25
34	11.95	334.60	358.50	370.45
35	12.14	339.92	364.20	376.34
36	12.33	345.24	369.90	382.23
37	12.53	350.84	375.90	388.43
38	12.72	356.16	381.60	394.32
39	12.92	361.76	387.60	400.52
40	13.11	367.08	393.30	406.41
41	13.30	372.40	399.00	412.30
42	13.50	378.00	405.00	418.50
43	13.69	383.32	410.70	424.39
44	13.89	388.92	416.70	430.59
45	14.08	394.24	422.40	436.48
46	14.27	399.56	428.10	442.37
47	14.47	405.16	434.10	448.57
48	14.66	410.48	439.80	454.46
49	14.86	416.08	445.80	460.66
50	15.05	421.40	451.50	466.55

(Add .195 to the daily rate for each point over 50)

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II(10)

INTERMEDIATE CARE FACILITY (ICF) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) V

The Counties included in HSA V are:

Alexander	Fayette	Jasper	Perry	Union
Bond	Franklin	Jefferson	Pope	Wabash
Clay	Gallatin	Johnson	Pulaski	Washington
Crawford	Hamilton	Lawrence	Randolph	Wayne
Edwards	Hardin	Marion	Richland	White
Effingham	Jackson	Massac	Saline	Williamson

Points	Daily Rates	Monthly Rates		
		28 Days	30 Days	31 Days
1	3.02	84.55	90.60	93.62
2	3.25	91.00	97.50	100.75
3	3.47	97.16	104.10	107.57
4	3.70	103.60	111.00	114.70
5	3.93	110.04	117.90	121.83
6	4.16	116.48	124.80	128.96
7	4.39	122.92	131.70	136.09
8	4.61	129.08	138.30	142.91
9	4.84	135.52	145.20	150.04
10	5.07	141.96	152.10	157.17
11	5.30	148.40	159.00	164.30
12	5.53	154.84	165.90	171.43
13	5.75	161.00	172.50	178.25
14	5.98	167.44	179.40	185.38
15	6.21	173.88	186.30	192.51
16	6.44	180.32	193.20	199.64
17	6.67	186.76	200.10	206.77
18	6.87	192.36	206.10	212.97
19	7.06	197.68	211.80	218.86
20	7.25	203.00	217.50	224.75
21	7.44	208.32	223.20	230.64
22	7.63	213.64	228.90	236.53
23	7.82	218.96	234.60	242.42
24	8.01	224.28	240.30	248.31

(Add .190 to the daily rate for each point over 24)

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II(11)

SKILLED NURSING FACILITY (SNF) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) V

The Counties included in HSA V are:

Alexander	Edwards	Gallatin	Jasper	Marion	Pulaski	Union	White
Bond	Effingham	Hamilton	Jefferson	Massac	Randolph	Wabash	Williamson
Clay	Fayette	Hardin	Johnson	Perry	Richland	Washington	
Crawford	Franklin	Jackson	Lawrence	Pope	Saline	Wayne	

Points	Daily Rates	Monthly Rates		
		28 Days	30 Days	31 Days
1	4.81	134.68	144.30	149.11
2	5.04	141.12	151.20	156.24
3	5.26	147.28	157.80	163.06
4	5.49	153.72	164.70	170.19
5	5.72	160.16	171.60	177.32
6	5.95	166.60	178.50	184.45
7	6.18	173.04	185.40	191.58
8	6.40	179.20	192.00	198.40
9	6.63	185.64	198.90	205.53
10	6.86	192.08	205.80	212.66
11	7.09	198.52	212.70	219.79
12	7.32	204.96	219.60	225.92
13	7.54	211.12	226.20	233.74
14	7.77	217.56	233.10	240.87
15	8.00	224.00	240.00	248.00
16	8.23	230.44	246.90	255.13
17	8.46	236.88	253.80	262.26
18	8.66	242.48	259.80	268.46
19	8.85	247.80	265.50	274.35
20	9.04	253.12	271.20	280.24
21	9.23	258.44	276.90	286.13
22	9.42	263.76	282.60	292.02
23	9.61	269.08	288.30	297.91
24	9.80	274.40	294.00	303.80
25	9.99	279.72	299.70	309.69
26	10.18	285.04	305.40	315.58
27	10.37	290.36	311.10	321.47
28	10.56	295.68	316.80	327.36
29	10.75	301.00	322.50	333.25
30	10.94	306.32	328.20	339.14
31	11.13	311.64	333.90	345.03
32	11.32	316.96	339.60	350.92
33	11.51	322.28	345.30	356.81
34	11.70	327.60	351.00	362.70
35	11.89	332.92	356.70	368.59
36	12.08	338.24	362.40	374.48
37	12.27	343.56	368.10	380.37
38	12.46	348.88	373.80	386.26
39	12.55	354.20	379.50	392.15
40	12.84	359.52	385.20	398.04
41	13.03	364.84	390.90	403.93
42	13.22	370.16	396.60	409.82
43	13.41	375.48	402.30	415.71
44	13.60	380.80	408.00	421.60
45	13.79	386.12	413.70	427.49
46	13.98	391.44	419.40	433.38
47	14.17	396.76	425.10	439.27
48	14.36	402.08	430.80	445.16
49	14.55	407.40	436.50	451.05
50	14.74	412.72	442.20	456.94

(Add .190 to the daily rate for each point over 50)

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II(12)

INTERMEDIATE CARE FACILITY (ICF) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) VI and VII

The Counties included in HSAs VI and VII are:

Cook and DuPage

Points	Daily Rates	Monthly Rates		
		28 Days	30 Days	31 Days
1	3.43	96.04	102.90	106.33
2	3.69	103.32	110.70	114.39
3	3.94	110.32	118.20	122.14
4	4.20	117.60	126.00	130.20
5	4.46	124.88	133.80	138.26
6	4.72	132.16	141.60	146.32
7	4.98	139.44	149.40	154.38
8	5.24	146.72	157.20	162.44
9	5.50	154.00	165.00	170.50
10	5.76	161.28	172.80	178.56
11	6.02	168.56	180.60	186.62
12	6.28	175.84	188.40	194.68
13	6.53	182.84	195.90	202.43
14	6.79	190.12	203.70	210.49
15	7.05	197.40	211.50	218.55
16	7.31	204.68	219.30	226.61
17	7.57	211.96	227.10	234.67
18	7.79	218.12	233.70	241.49
19	8.01	224.28	240.30	248.31
20	8.23	230.44	246.90	255.13
21	8.44	236.32	253.20	261.64
22	8.65	242.43	259.80	268.45
23	8.87	248.36	266.10	274.97
24	9.09	254.52	272.70	281.79

(Add .216 to the daily rate for each point over 24)

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II(13)

SKILLED NURSING FACILITY (SNF) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) VI & VII

The Counties included in HSAs VI & VII are:

Cook and DuPage

Points	Daily Rates	Monthly Rates		
		28 Days	30 Days	31 Days
1	5.46	152.88	163.80	169.26
2	5.72	160.16	171.60	177.32
3	5.98	167.44	179.40	185.38
4	6.24	174.72	187.20	193.44
5	6.49	181.72	194.70	201.19
6	6.75	189.00	202.50	209.25
7	7.01	196.28	210.30	217.31
8	7.27	203.56	218.10	225.37
9	7.53	210.84	225.90	233.43
10	7.79	218.12	233.70	241.49
11	8.05	225.40	241.50	249.55
12	8.31	232.68	249.30	257.61
13	8.57	239.96	257.10	265.67
14	8.83	247.24	264.90	273.73
15	9.08	254.24	272.40	281.48
16	9.34	261.52	280.20	289.54
17	9.60	268.80	288.00	297.60
18	9.83	275.24	294.90	304.73
19	10.04	281.12	301.20	311.24
20	10.25	287.28	307.80	318.06
21	10.47	293.16	314.10	324.57
22	10.69	299.32	320.70	331.39
23	10.91	305.48	327.30	338.21
24	11.12	311.36	333.60	344.72
25	11.34	317.52	340.20	351.54
26	11.55	323.40	346.50	358.05
27	11.77	329.56	352.10	364.87
28	11.99	335.72	359.70	371.69
29	12.20	341.60	366.00	378.20
30	12.42	347.76	372.60	385.02
31	12.63	353.64	378.90	391.53
32	12.85	359.63	385.50	398.35
33	13.07	365.96	392.10	405.17
34	13.28	371.84	398.40	411.68
35	13.50	378.00	405.00	418.50
36	13.71	383.88	411.30	425.01
37	13.93	390.04	417.90	431.83
38	14.15	396.20	424.50	438.65
39	14.36	402.08	430.80	445.16
40	14.58	408.24	437.40	451.98
41	14.79	414.12	443.70	458.49
42	15.01	420.28	450.30	465.31
43	15.23	426.44	456.90	472.13
44	15.44	432.32	463.20	478.64
45	15.66	438.48	469.80	485.46
46	15.87	444.36	476.10	491.97
47	16.09	450.52	482.70	498.79
48	16.31	456.68	489.30	505.61
49	16.52	462.56	495.60	512.12
50	16.74	468.72	502.20	518.94

(Add .210 to the daily rate for each point over 50)

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II(14)

INTERMEDIATE CARE FACILITY (ICF) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) VIII

The Counties included in HSA VIII are:

Kane McHenry Lake

Points	Daily Rates	Monthly Rates		
		28 Days	30 Days	31 Days
1	3.32	92.96	99.60	102.92
2	3.57	99.96	107.10	110.67
3	3.82	106.96	114.60	118.42
4	4.07	113.96	122.10	126.17
5	4.32	120.96	129.60	133.92
6	4.57	127.96	137.10	141.67
7	4.83	135.24	144.90	149.73
8	5.08	142.24	152.40	157.48
9	5.33	149.24	159.90	165.23
10	5.58	156.24	167.40	172.98
11	5.83	163.24	174.90	180.73
12	6.08	170.24	182.40	188.48
13	6.33	177.24	189.90	196.23
14	6.58	184.24	197.40	203.98
15	6.83	191.24	204.90	211.73
16	7.08	198.24	212.40	219.48
17	7.34	205.52	220.20	227.54
18	7.55	211.40	226.50	234.05
19	7.76	217.28	232.80	240.56
20	7.97	223.16	239.10	247.07
21	8.18	229.04	245.40	253.58
22	8.39	234.92	251.70	260.09
23	8.59	240.52	257.70	266.29
24	8.80	246.40	264.00	272.80

(Add .209 to the daily rate for each point over 24)

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II(15)

SKILLED NURSING FACILITY (SNF) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) VIII

The Counties included in HSA VIII are:

Kane McHenry Lake

Points	Daily Rates	Monthly Rates		
		28 Days	30 Days	31 Days
1	5.29	148.12	158.70	163.99
2	5.54	155.12	166.20	171.74
3	5.79	162.12	173.70	179.49
4	6.04	169.12	181.20	187.24
5	6.29	176.12	188.70	194.99
6	6.54	183.12	196.20	202.74
7	6.79	190.12	203.70	210.49
8	7.04	197.12	211.20	218.24
9	7.30	204.40	219.00	225.30
10	7.55	211.40	226.50	234.05
11	7.80	218.40	234.00	241.80
12	8.05	225.40	241.50	249.55
13	8.30	232.40	249.00	257.30
14	8.55	239.40	256.50	265.05
15	8.80	246.40	264.00	272.80
16	9.05	253.40	271.50	280.55
17	9.30	260.40	279.00	288.30
18	9.52	266.56	285.60	295.12
19	9.73	272.44	291.90	301.63
20	9.94	278.32	298.20	308.14
21	10.14	283.92	304.20	314.34
22	10.35	289.80	310.50	320.85
23	10.56	295.68	316.80	327.36
24	10.77	301.56	323.10	333.87
25	10.98	307.44	329.40	340.38
26	11.19	313.32	335.70	346.89
27	11.40	319.20	342.00	353.40
28	11.61	325.08	348.30	359.91
29	11.82	330.96	354.60	366.42
30	12.03	336.84	360.90	372.93
31	12.23	342.44	366.90	379.13
32	12.44	348.32	373.20	385.64
33	12.65	354.20	379.50	392.15
34	12.86	360.08	385.80	398.66
35	13.07	365.96	392.10	405.17
36	13.28	371.84	398.40	411.68
37	13.49	377.72	404.70	418.19
38	13.70	383.60	411.00	424.70
39	13.91	389.48	417.30	431.21
40	14.12	395.36	423.60	437.72
41	14.32	400.96	429.60	443.92
42	14.53	406.84	435.90	450.43
43	14.74	412.72	442.20	456.94
44	14.95	418.60	448.50	463.45
45	15.16	424.48	454.80	469.96
46	15.37	430.36	461.10	476.47
47	15.58	436.24	467.40	482.98
48	15.79	442.12	473.70	489.49
49	16.00	448.00	480.00	496.00
50	16.21	453.88	486.30	502.51

(Add .209 to the daily rate for each point over 50)

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II(16)

INTERMEDIATE CARE FACILITY (ICF) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) IX

The Counties included in HSA IX are:

Grundy Kankakee Kendall Will

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	3.04	85.12	91.20	94.24
2	3.27	91.56	98.10	101.37
3	3.50	98.00	105.00	108.50
4	3.73	104.44	111.90	115.63
5	3.95	110.88	118.80	122.76
6	4.19	117.32	125.70	129.89
7	4.42	123.76	132.60	137.02
8	4.65	130.20	139.50	144.15
9	4.88	136.64	146.40	151.28
10	5.11	143.08	153.30	158.41
11	5.34	149.52	160.20	165.54
12	5.57	155.96	167.10	172.67
13	5.80	162.40	174.00	179.80
14	6.03	168.84	180.90	186.93
15	6.26	175.28	187.80	194.06
16	6.49	181.72	194.70	201.19
17	6.72	188.16	201.60	208.32
18	6.93	194.04	207.90	214.83
19	7.12	199.36	213.60	220.72
20	7.31	204.68	219.30	226.61
21	7.50	210.00	225.00	232.50
22	7.69	215.32	230.70	238.39
23	7.89	220.92	236.70	244.59
24	8.08	226.24	242.40	250.48

(Add .191 to the daily rate for each point over 24)

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II(17)

SKILLED NURSING FACILITY (SNF) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) IX

The Counties included in HSA IX are:

Grundy Kankakee Kendall Will

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	4.85	135.80	145.50	150.35
2	5.08	142.24	152.40	157.48
3	5.31	148.68	159.30	164.61
4	5.54	155.12	166.20	171.74
5	5.77	161.56	173.10	178.87
6	6.00	168.00	180.00	186.00
7	6.23	174.44	186.90	193.13
8	6.46	180.88	193.80	200.26
9	6.69	187.32	200.70	207.39
10	6.92	193.76	207.60	214.52
11	7.15	200.20	214.50	221.65
12	7.38	206.64	221.40	228.78
13	7.61	213.08	228.30	235.91
14	7.84	219.52	235.20	243.04
15	8.07	225.96	242.10	250.17
16	8.30	232.40	249.00	257.30
17	8.53	238.84	255.90	264.43
18	8.73	244.44	261.90	270.63
19	8.92	249.76	267.60	276.52
20	9.11	255.08	273.30	282.41
21	9.31	260.68	279.30	288.61
22	9.50	266.00	285.00	294.50
23	9.69	271.32	290.70	300.39
24	9.88	276.64	296.40	306.28
25	10.07	281.96	302.10	312.17
26	10.27	287.56	308.10	318.37
27	10.46	292.88	313.80	324.26
28	10.65	298.20	319.50	330.15
29	10.84	303.52	325.20	336.04
30	11.03	308.84	330.90	341.93
31	11.23	314.44	336.90	348.13
32	11.42	319.76	342.60	354.02
33	11.61	325.08	348.30	359.91
34	11.80	330.40	354.00	365.80
35	11.99	335.72	359.70	371.69
36	12.19	341.32	365.70	377.89
37	12.38	346.64	371.40	383.78
38	12.57	351.96	377.10	389.67
39	12.76	357.28	382.80	395.56
40	12.95	362.60	388.50	401.45
41	13.15	368.20	394.50	407.65
42	13.34	373.52	400.20	413.54
43	13.53	378.84	405.90	419.43
44	13.72	384.16	411.60	425.32
45	13.91	389.48	417.30	431.21
46	14.11	395.08	423.30	437.41
47	14.30	400.40	429.00	443.30
48	14.49	405.72	434.70	449.19
49	14.68	411.04	440.40	455.08
50	14.87	416.36	446.10	460.97

(Add .191 to the daily rate for each point over 50)

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II(18)

INTERMEDIATE CARE FACILITY (ICF) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) X

The Counties included in HSA X are:

Henry Mercer Rock Island

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	3.16	88.48	94.80	97.96
2	3.40	95.20	102.00	105.40
3	3.64	101.92	109.20	112.84
4	3.88	108.64	116.40	120.28
5	4.12	115.36	123.60	127.72
6	4.36	122.08	130.80	135.16
7	4.59	128.52	137.70	142.29
8	4.83	135.24	144.90	149.73
9	5.07	141.96	152.10	157.17
10	5.31	148.68	159.30	164.61
11	5.55	155.40	166.50	172.05
12	5.79	162.12	173.70	179.49
13	6.03	168.84	180.90	186.93
14	6.27	175.56	188.10	194.37
15	6.51	182.28	195.30	201.81
16	6.75	189.00	202.50	209.25
17	6.93	195.44	209.40	216.38
18	7.19	201.32	215.70	222.89
19	7.39	206.92	221.70	229.09
20	7.59	212.52	227.70	235.29
21	7.79	218.12	233.70	241.49
22	7.98	223.44	239.40	247.38
23	8.18	229.04	245.40	253.58
24	8.38	234.64	251.40	259.78

(Add .199 to the daily rate for each point over 24)

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II(19)

SKILLED NURSING FACILITY (SNF) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) X

The Counties included in HSA X are:

Henry Mercer Rock Island

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	5.03	140.84	150.90	155.93
2	5.27	147.56	158.10	163.37
3	5.51	154.28	165.30	170.81
4	5.75	161.00	172.50	178.25
5	5.99	167.72	179.70	185.69
6	6.23	174.44	186.90	193.13
7	6.47	181.16	194.10	200.57
8	6.71	187.88	201.30	208.01
9	6.95	194.60	208.50	215.45
10	7.19	201.32	215.70	222.89
11	7.42	207.76	222.60	230.02
12	7.66	214.48	229.80	237.46
13	7.90	221.20	237.00	244.90
14	8.14	227.92	244.20	252.34
15	8.38	234.64	251.40	259.78
16	8.62	241.36	258.60	267.22
17	8.86	248.08	265.80	274.66
18	9.06	253.68	271.80	280.86
19	9.26	259.28	277.80	287.06
20	9.46	264.88	283.80	293.26
21	9.66	270.48	289.80	299.46
22	9.86	276.08	295.80	305.66
23	10.06	281.68	301.80	311.86
24	10.26	287.28	307.80	318.06
25	10.46	292.88	313.80	324.26
26	10.65	298.20	319.50	330.15
27	10.85	303.80	325.50	336.35
28	11.05	309.40	331.50	342.55
29	11.25	315.00	337.50	348.75
30	11.45	320.60	343.50	354.95
31	11.65	326.20	349.50	361.15
32	11.85	331.80	355.50	367.35
33	12.05	337.40	361.50	373.55
34	12.25	343.00	367.50	379.75
35	12.45	348.60	373.50	385.95
36	12.64	353.92	379.20	391.84
37	12.84	359.52	385.20	398.04
38	13.04	365.12	391.20	404.24
39	13.24	370.72	397.20	410.44
40	13.44	376.32	403.20	416.64
41	13.64	381.92	409.20	422.54
42	13.84	387.52	415.20	429.04
43	14.04	393.12	421.20	435.24
44	14.24	398.72	427.20	441.44
45	14.44	404.32	433.20	447.64
46	14.63	409.64	438.90	453.53
47	14.83	415.24	444.90	459.73
48	15.03	420.84	450.90	465.93
49	15.23	426.44	456.90	472.13
50	15.43	432.04	462.90	478.33

(Add .199 to the daily rate for each point over 50)

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II(20)

INTERMEDIATE CARE FACILITY (ICF) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) XI

The Counties included in HSA XI are:

Clinton Madison Monroe St. Clair

Points	Daily Rates	Monthly Rates		
		29 Days	30 Days	31 Days
1	3.12	87.36	93.60	96.72
2	3.36	94.08	100.80	104.16
3	3.59	100.52	107.70	111.29
4	3.83	107.24	114.90	118.73
5	4.07	113.96	122.10	126.17
6	4.30	120.40	129.00	133.30
7	4.54	127.12	136.20	140.74
8	4.77	133.56	143.10	147.87
9	5.01	140.28	150.30	155.31
10	5.25	147.00	157.50	162.75
11	5.48	153.44	164.40	169.83
12	5.72	160.16	171.60	177.32
13	5.95	166.60	178.50	184.45
14	6.19	173.32	185.70	191.89
15	6.43	180.04	192.90	199.33
16	6.65	186.48	199.80	206.46
17	6.90	193.20	207.00	213.90
18	7.10	198.80	213.00	220.10
19	7.30	204.40	219.00	226.30
20	7.50	210.00	225.00	232.50
21	7.69	215.32	230.70	238.39
22	7.89	220.92	236.70	244.59
23	8.09	226.52	242.70	250.79
24	8.29	232.12	248.70	256.99

(Add .197 to the daily rate for each point over 24)

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II(21)

SKILLED NURSING FACILITY (SNF) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) XI

The Counties included in HSA XI are:

Clinton Madison Monroe St. Clair

Points	Daily Rates	Monthly Rates		
		28 Days	30 Days	31 Days
1	4.97	139.16	149.10	154.07
2	5.21	145.88	156.30	161.51
3	5.45	152.60	163.50	168.95
4	5.68	159.04	170.40	176.08
5	5.92	165.76	177.60	183.52
6	6.15	172.20	184.50	190.65
7	6.39	178.92	191.70	198.09
8	6.63	185.64	198.90	205.53
9	6.86	192.08	205.80	212.66
10	7.10	198.80	213.00	220.10
11	7.33	205.24	219.90	227.23
12	7.57	211.96	227.10	234.67
13	7.81	218.68	234.30	242.11
14	8.04	225.12	241.20	249.24
15	8.28	231.84	248.40	256.68
16	8.51	238.28	255.30	263.81
17	8.75	245.00	262.50	271.25
18	8.96	250.88	268.80	277.76
19	9.15	256.20	274.50	283.65
20	9.35	261.80	280.50	289.85
21	9.55	267.40	286.50	296.05
22	9.74	272.72	292.20	301.94
23	9.94	278.32	298.20	308.14
24	10.14	283.92	304.20	314.34
25	10.33	289.24	309.90	320.23
26	10.53	294.84	315.90	326.43
27	10.73	300.44	321.90	332.63
28	10.93	306.04	327.90	338.83
29	11.12	311.36	333.60	344.72
30	11.32	316.96	339.60	350.92
31	11.52	322.56	345.60	357.12
32	11.71	327.88	351.30	363.01
33	11.91	333.48	357.30	369.21
34	12.11	339.08	363.30	375.41
35	12.30	344.40	369.00	381.30
36	12.50	350.00	375.00	387.50
37	12.70	355.60	381.00	393.70
38	12.90	361.20	387.00	399.90
39	13.09	366.52	392.70	405.79
40	13.29	372.12	398.70	411.99
41	13.49	377.72	404.70	418.19
42	13.68	383.04	410.40	424.08
43	13.88	388.64	416.40	430.28
44	14.08	394.24	422.40	436.48
45	14.27	399.56	428.10	442.37
46	14.47	405.16	434.10	448.57
47	14.67	410.76	440.10	454.77
48	14.87	416.36	446.10	460.97
49	15.06	421.68	451.80	466.86
50	15.26	427.28	457.80	473.06

(Add .197 to the daily rate for each point over 50)

O B S O L E T E

RATE SCHEDULE FOR ICF/MR PAYMENT - GROUP II - JULY 1, 1977

Provisional				Full Status		
Not Qualified for "SHELTER FACTOR" ALLOWANCE				Includes "SHELTER FACTOR" ALLOWANCE		
Regular Rate	Approved Activity Program Only	Approved RN&A Program	Point Count	Regular Rate	Approved Activity Program Only	Approved RN&A Program
$337.00	$345.00	$357.00	0-7	$404.00	$412.00	$424.00
342.00	350.00	362.00	8	409.00	417.00	429.00
347.00	355.00	367.00	9	414.00	422.00	434.00
352.00	360.00	372.00	10	419.00	427.00	439.00
357.00	365.00	377.00	11	424.00	432.00	444.00
362.00	370.00	382.00	12	429.00	437.00	449.00
367.00	375.00	387.00	13	434.00	442.00	454.00
372.00	380.00	392.00	14	439.00	447.00	459.00
377.00	385.00	397.00	15	444.00	452.00	464.00
382.00	390.00	402.00	16	449.00	457.00	469.00
387.00	395.00	407.00	17	454.00	462.00	474.00
392.00	400.00	412.00	18	459.00	467.00	479.00
397.00	405.00	417.00	19	464.00	472.00	484.00
402.00	410.00	422.00	20	469.00	477.00	489.00
407.00	415.00	427.00	21	474.00	482.00	494.00
412.00	420.00	432.00	22	479.00	487.00	499.00
417.00	425.00	437.00	23	484.00	492.00	504.00
422.00	430.00	442.00	24	489.00	497.00	509.00
427.00	435.00	447.00	25	494.00	502.00	514.00
432.00	440.00	452.00	26	499.00	507.00	519.00
437.00	445.00	457.00	27	504.00	512.00	524.00
442.00	450.00	462.00	28	509.00	517.00	529.00
447.00	455.00	467.00	29	514.00	522.00	534.00
452.00	460.00	472.00	30	519.00	527.00	539.00
457.00	465.00	477.00	31	524.00	532.00	544.00
462.00	470.00	482.00	32	529.00	537.00	549.00
467.00	475.00	487.00	33	534.00	542.00	554.00
472.00	480.00	492.00	34	539.00	547.00	559.00
477.00	485.00	497.00	35	544.00	552.00	564.00
482.00	490.00	502.00	36	549.00	557.00	569.00
487.00	495.00	507.00	37	554.00	562.00	574.00
492.00	500.00	512.00	38	559.00	567.00	579.00
497.00	505.00	517.00	39	564.00	572.00	584.00
502.00	510.00	522.00	40	569.00	577.00	589.00
507.00	515.00	527.00	41	574.00	582.00	594.00
512.00	520.00	532.00	42	579.00	587.00	599.00
517.00	525.00	537.00	43	584.00	592.00	604.00
522.00	530.00	542.00	44	589.00	597.00	609.00
527.00	535.00	547.00	45	594.00	602.00	614.00
532.00	540.00	552.00	46	599.00	607.00	619.00
537.00	545.00	557.00	47	604.00	612.00	624.00
542.00	550.00	562.00	48	609.00	617.00	629.00
547.00	555.00	567.00	49	614.00	622.00	634.00
552.00	560.00	572.00	50	619.00	627.00	639.00

OBSOLETE

RATE SCHEDULE FOR ICF/MR PAYMENT - GROUP III - JULY 1, 1977

Provisional				Full Status		
Not Qualified for "SHELTER FACTOR" ALLOWANCE				Includes "SHELTER FACTOR" ALLOWANCE		
Regular Rate	Approved Activity Program Only	Approved RN&A Program	Point Count	Regular Rate	Approved Activity Program Only	Approved RN&A Program
$355.00	$363.00	$375.00	0-7	$421.00	$429.00	$441.00
361.00	369.00	381.00	8	427.00	435.00	447.00
367.00	375.00	387.00	9	433.00	441.00	453.00
373.00	381.00	393.00	10	439.00	447.00	459.00
379.00	387.00	399.00	11	445.00	453.00	465.00
385.00	393.00	405.00	12	451.00	459.00	471.00
391.00	399.00	411.00	13	457.00	465.00	477.00
397.00	405.00	417.00	14	463.00	471.00	483.00
403.00	411.00	423.00	15	469.00	477.00	489.00
409.00	417.00	429.00	16	475.00	483.00	495.00
415.00	423.00	435.00	17	481.00	489.00	501.00
421.00	429.00	441.00	18	487.00	495.00	507.00
427.00	435.00	447.00	19	493.00	501.00	513.00
433.00	441.00	453.00	20	499.00	507.00	519.00
439.00	447.00	459.00	21	505.00	513.00	525.00
445.00	453.00	465.00	22	511.00	519.00	531.00
451.00	459.00	471.00	23	517.00	525.00	537.00
457.00	465.00	477.00	24	523.00	531.00	543.00
463.00	471.00	483.00	25	529.00	537.00	549.00
469.00	477.00	489.00	26	535.00	543.00	555.00
475.00	483.00	495.00	27	541.00	449.00	561.00
481.00	489.00	501.00	28	547.00	555.00	567.00
487.00	495.00	507.00	29	553.00	561.00	573.00
493.00	501.00	513.00	30	559.00	567.00	579.00
499.00	507.00	519.00	31	565.00	573.00	585.00
505.00	513.00	525.00	32	571.00	579.00	591.00
511.00	519.00	531.00	33	577.00	585.00	597.00
517.00	525.00	537.00	34	583.00	591.00	603.00
523.00	531.00	543.00	35	589.00	597.00	609.00
529.00	537.00	549.00	36	595.00	603.00	615.00
535.00	543.00	555.00	37	601.00	609.00	621.00
541.00	549.00	561.00	38	607.00	615.00	627.00
547.00	555.00	567.00	39	613.00	621.00	633.00
553.00	561.00	573.00	40	619.00	627.00	639.00
559.00	567.00	579.00	41	625.00	633.00	645.00
565.00	573.00	585.00	42	631.00	639.00	651.00
571.00	579.00	591.00	43	637.00	645.00	657.00
577.00	585.00	597.00	44	643.00	651.00	663.00
583.00	591.00	603.00	45	649.00	657.00	669.00
589.00	597.00	609.00	46	655.00	663.00	675.00
595.00	603.00	615.00	47	661.00	669.00	681.00
601.00	609.00	621.00	48	667.00	675.00	687.00
607.00	615.00	627.00	49	673.00	681.00	693.00
613.00	621.00	633.00	50	679.00	687.00	699.00

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II (22)

NEW

INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR)
NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) I

Effective 1-1-78

The Counties included in HSA I are:

Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	4.40	123.20	132.00	136.40
2	4.50	126.00	135.00	139.50
3	4.59	128.52	137.70	142.29
4	4.69	131.32	140.70	145.39
5	4.79	134.12	143.70	148.49
6	4.88	136.64	146.40	151.28
7	4.98	139.44	149.40	154.38
8	5.08	142.24	152.40	157.48
9	5.18	145.04	155.40	160.58
10	5.27	147.56	158.10	163.37
11	5.37	150.36	161.10	166.47
12	5.47	153.16	164.10	169.57
13	5.56	155.68	166.80	172.36
14	5.66	158.48	169.80	175.46
15	5.76	161.28	172.80	178.56
16	5.85	163.80	175.50	181.35
17	5.95	166.60	178.50	184.45
18	6.05	169.40	181.50	187.55
19	6.15	172.20	184.50	190.65
20	6.24	174.72	187.20	193.44
21	6.34	177.52	190.20	196.54
22	6.44	180.32	193.20	199.64
23	6.53	182.84	195.90	202.43
24	6.63	185.64	198.90	205.53
25	6.73	188.44	201.90	208.63
26	6.82	190.96	204.60	211.42
27	6.92	193.76	207.60	214.52
28	7.02	196.56	210.60	217.62
29	7.12	199.36	213.60	220.72
30	7.21	201.88	216.30	223.51
31	7.31	204.68	219.30	226.61
32	7.41	207.48	222.30	229.71
33	7.50	210.00	225.00	232.50
34	7.60	212.80	228.00	235.60
35	7.70	215.60	231.00	238.70
36	7.79	218.12	233.70	241.49
37	7.89	220.92	236.70	244.59
38	7.99	223.72	239.70	247.69
39	8.09	226.52	242.70	250.79
40	8.18	229.04	245.40	253.58
41	8.28	231.84	248.40	256.68
42	8.38	234.64	251.40	259.78
43	8.47	237.16	254.10	262.57
44	8.57	239.96	257.10	265.67
45	8.67	242.76	260.10	268.77
46	8.76	245.28	262.80	271.56
47	8.86	248.08	265.80	274.66
48	8.96	250.88	268.80	277.76
49	9.06	253.68	271.80	280.86
50	9.15	256.20	274.50	283.65

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II (23)

NEW

INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR)
NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) II

Effective 1-1-78

The Counties included in HSA II are:

Bureau, Fulton, Henderson, Knox, LaSalle, Marshall, McDonough, Peoria, Putnam, Stark, Tazewell, Warren, Woodford

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	4.48	125.44	134.40	138.88
2	4.58	128.24	137.40	141.98
3	4.68	131.04	140.40	145.08
4	4.78	133.84	143.40	148.18
5	4.87	136.36	146.10	150.97
6	4.97	139.16	149.10	154.07
7	5.07	141.96	152.10	157.17
8	5.17	144.76	155.10	160.27
9	5.27	147.56	158.10	163.37
10	5.37	150.36	161.10	166.47
11	5.47	153.16	164.10	169.57
12	5.57	155.96	167.10	172.67
13	5.67	158.76	170.10	175.77
14	5.77	161.56	173.10	178.87
15	5.86	164.08	175.80	181.66
16	5.96	166.88	178.80	184.76
17	6.06	169.68	181.80	187.86
18	6.16	172.48	184.80	190.96
19	6.26	175.28	187.80	194.06
20	6.36	178.08	190.80	197.16
21	6.46	180.88	193.80	200.26
22	6.56	183.68	196.80	203.36
23	6.66	186.48	199.80	206.46
24	6.76	189.28	202.80	209.56
25	6.85	191.80	205.50	212.35
26	6.95	194.60	208.50	215.45
27	7.05	197.40	211.50	218.55
28	7.15	200.20	214.50	221.65
29	7.25	203.00	217.50	224.75
30	7.35	205.80	220.50	227.85
31	7.45	208.60	223.50	230.95
32	7.55	211.40	226.50	234.05
33	7.65	214.20	229.50	237.15
34	7.75	217.00	232.50	240.25
35	7.84	219.52	235.20	243.04
36	7.94	222.32	238.20	246.14
37	8.04	225.12	241.20	249.24
38	8.14	227.92	244.20	252.34
39	8.24	230.72	247.20	255.44
40	8.34	233.52	250.20	258.54
41	8.44	236.32	253.20	261.64
42	8.54	239.12	256.20	264.74
43	8.64	241.92	259.20	267.84
44	8.74	244.72	262.20	270.94
45	8.83	247.24	264.90	273.73
46	8.93	250.04	267.90	276.83
47	9.03	252.84	270.90	279.93
48	9.13	255.64	273.90	283.03
49	9.23	258.44	276.90	286.13
50	9.33	261.24	279.90	289.23

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II (24)

NEW

INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR)
NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) III

Effective 1-1-78

The Counties included in HSA III are:

Adams	Christian	Logan	Montgomery	Schuyler
Brown	Green	Macoupin	Morgan	Scott
Calhoun	Hancock	Mason	Pike	
Cass	Jersey	Menard	Sangamon	

Points	Daily Rates	Monthly Rates		
		28 Days	30 Days	31 Days
1	4.47	125.16	134.10	138.57
2	4.57	127.96	137.10	141.67
3	4.67	130.76	140.10	144.77
4	4.76	133.28	142.80	147.56
5	4.86	136.08	145.80	150.66
6	4.96	138.88	148.80	153.76
7	5.06	141.68	151.80	156.86
8	5.16	144.48	154.80	159.96
9	5.26	147.28	157.80	163.06
10	5.36	150.08	160.80	166.16
11	5.46	152.88	163.80	169.26
12	5.56	155.68	166.80	172.36
13	5.66	158.48	169.80	175.46
14	5.75	161.00	172.50	178.25
15	5.85	163.80	175.50	181.35
16	5.95	166.60	178.50	184.45
17	6.05	169.40	181.50	187.55
18	6.15	172.20	184.50	190.65
19	6.25	175.00	187.50	193.75
20	6.35	177.80	190.50	196.85
21	6.45	180.60	193.50	199.95
22	6.55	183.40	196.50	203.05
23	6.65	186.20	199.50	206.15
24	6.74	188.72	202.20	208.94
25	6.84	191.52	205.20	212.04
26	6.94	194.32	208.20	215.14
27	7.04	197.12	211.20	218.24
28	7.14	199.92	214.20	221.34
29	7.24	202.72	217.20	224.44
30	7.34	205.52	220.20	227.54
31	7.44	208.32	223.20	230.64
32	7.54	211.12	226.20	233.74
33	7.64	213.92	229.20	236.84
34	7.73	216.44	231.90	239.63
35	7.83	219.24	234.90	242.73
36	7.93	222.04	237.90	245.83
37	8.03	224.84	240.90	248.93
38	8.13	227.64	243.90	252.03
39	8.23	230.44	246.90	255.13
40	8.33	233.24	249.90	258.23
41	8.43	236.04	252.90	261.33
42	8.53	238.84	255.90	264.43
43	8.63	241.64	258.90	267.53
44	8.72	244.16	261.60	270.32
45	8.82	246.96	264.60	273.42
46	8.92	249.76	267.60	276.52
47	9.02	252.56	270.60	279.62
48	9.12	255.36	273.60	282.72
49	9.22	258.16	276.60	285.82
50	9.32	260.96	279.60	288.92

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RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II (25)

NEW

INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR)
NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) IV

Effective 1-1-78

The Counties included in HSA IV are:

Champaign	DeWitt	Ford	Macon	Piatt
Clark	Douglas	Iroquois	McLean	Shelby
Coles	Edgar	Livingston	Moultrie	Vermilion
Cumberland				

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	4.49	125.72	134.70	139.19
2	4.59	128.52	137.70	142.29
3	4.69	131.32	140.70	145.39
4	4.79	134.12	143.70	148.49
5	4.89	136.92	146.70	151.59
6	4.99	139.72	149.70	154.69
7	5.09	142.52	152.70	157.79
8	5.19	145.32	155.70	160.89
9	5.29	148.12	158.70	163.99
10	5.39	150.92	161.70	167.09
11	5.49	153.72	164.70	170.19
12	5.59	156.52	167.70	173.29
13	5.69	159.32	170.70	176.39
14	5.79	162.12	173.70	179.49
15	5.89	164.92	176.70	182.59
16	5.99	167.72	179.70	185.69
17	6.09	170.52	182.70	188.79
18	6.19	173.32	185.70	191.89
19	6.29	176.12	188.70	194.99
20	6.39	178.92	191.70	198.09
21	6.49	181.72	194.70	201.19
22	6.59	184.52	197.70	204.29
23	6.69	187.32	200.70	207.39
24	6.79	190.12	203.70	210.49
25	6.89	192.92	206.70	213.59
26	6.99	195.72	209.70	216.69
27	7.09	198.52	212.70	219.79
28	7.19	201.32	215.70	222.89
29	7.29	204.12	218.70	225.99
30	7.39	206.92	221.70	229.09
31	7.49	209.72	224.70	232.19
32	7.59	212.52	227.70	235.29
33	7.69	215.32	230.70	238.39
34	7.79	218.12	233.70	241.49
35	7.89	220.92	236.70	244.59
36	7.99	223.72	239.70	247.69
37	8.09	226.52	242.70	250.79
38	8.19	229.32	245.70	253.89
39	8.29	232.12	248.70	256.99
40	8.39	234.92	251.70	260.09
41	8.49	237.72	254.70	263.19
42	8.59	240.52	257.70	266.29
43	8.69	243.32	260.70	269.39
44	8.79	246.12	263.70	272.49
45	8.89	248.92	266.70	275.59
46	8.99	251.72	269.70	278.69
47	9.09	254.52	272.70	281.79
48	9.19	257.32	275.70	284.89
49	9.29	260.12	278.70	287.99
50	9.39	262.92	281.70	291.09

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II (26)

NEW

INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR)
NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) V

Effective 1-1-73

The Counties included in HSA V are:

Alexander	Edwards	Gallatin	Jasper	Marion	Pulaski	Union	White
Bond	Effingham	Hamilton	Jefferson	Massac	Randolph	Wabash	Williamson
Clay	Fayette	Hardin	Johnson	Perry	Richland	Washington	
Crawford	Franklin	Jackson	Lawrence	Pope	Saline	Wayne	

Points	Daily Rates	Monthly Rates		
		28 Days	30 Days	31 Days
1	4.41	123.48	132.30	136.71
2	4.51	126.28	135.30	139.81
3	4.60	128.80	138.00	142.60
4	4.70	131.60	141.00	145.70
5	4.80	134.40	144.00	148.80
6	4.90	137.20	147.00	151.90
7	4.99	139.72	149.70	154.69
8	5.09	142.52	152.70	157.79
9	5.19	145.32	155.70	160.89
10	5.28	147.84	158.40	163.68
11	5.33	150.64	161.40	166.78
12	5.43	153.44	164.40	169.88
13	5.57	155.96	167.10	172.67
14	5.67	158.76	170.10	175.77
15	5.77	161.56	173.10	178.87
16	5.87	164.36	176.10	181.97
17	5.96	166.88	178.80	184.76
18	6.06	169.68	181.80	187.86
19	6.16	172.48	184.80	190.96
20	6.25	175.00	187.50	193.75
21	6.35	177.80	190.50	196.85
22	6.45	180.60	193.50	199.95
23	6.54	183.12	196.20	202.74
24	6.64	185.92	199.20	205.84
25	6.74	188.72	202.20	208.94
26	6.84	191.52	205.20	212.04
27	6.93	194.04	207.90	214.83
28	7.03	196.84	210.90	217.93
29	7.13	199.64	213.90	221.03
30	7.22	202.16	216.60	223.82
31	7.32	204.96	219.60	226.92
32	7.42	207.76	222.60	230.02
33	7.51	210.28	225.30	232.81
34	7.61	213.08	228.30	235.91
35	7.71	215.88	231.30	239.01
36	7.81	218.68	234.30	242.11
37	7.90	221.20	237.00	244.90
38	8.00	224.00	240.00	248.00
39	8.10	226.80	243.00	251.10
40	8.19	229.32	245.70	253.89
41	8.29	232.12	248.70	256.99
42	8.39	234.92	251.70	260.09
43	8.48	237.44	254.40	262.88
44	8.58	240.24	257.40	265.98
45	8.68	243.04	260.40	269.08
46	8.78	245.84	263.40	272.18
47	8.87	248.36	266.10	274.97
48	8.97	251.16	269.10	278.07
49	9.07	253.96	272.10	281.17
50	9.16	256.48	274.80	283.95

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RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II (27)

NEW

INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR)
NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) VI & VII

Effective 1-1-78

The Counties included in HSAs VI & VII are:

Cook and DuPage

Points	Daily Rates	Monthly Rates		
		28 Days	30 Days	31 Days
1	4.99	139.72	149.70	154.69
2	5.11	143.08	153.30	158.41
3	5.23	146.44	156.90	162.13
4	5.34	149.52	160.20	165.54
5	5.46	152.88	163.80	169.26
6	5.58	156.24	167.40	172.98
7	5.69	159.32	170.70	176.39
8	5.81	162.68	174.30	180.11
9	5.93	166.04	177.90	183.83
10	6.04	169.12	181.20	187.24
11	6.16	172.48	184.80	190.96
12	6.28	175.84	188.40	194.68
13	6.40	179.20	192.00	198.40
14	6.51	182.28	195.30	201.81
15	6.63	185.64	198.90	205.53
16	6.75	189.00	202.50	209.25
17	6.86	192.08	205.80	212.66
18	6.98	195.44	209.40	216.38
19	7.10	198.80	213.00	220.10
20	7.21	201.88	216.30	223.51
21	7.33	205.24	219.90	227.23
22	7.45	208.60	223.50	230.95
23	7.56	211.68	226.80	234.36
24	7.68	215.04	230.40	238.08
25	7.80	218.40	234.00	241.80
26	7.91	221.48	237.30	245.21
27	8.03	224.84	240.90	248.93
28	8.15	228.20	244.50	252.65
29	8.27	231.56	248.10	256.37
30	8.38	234.64	251.40	259.78
31	8.50	238.00	255.00	263.50
32	8.62	241.36	258.60	267.22
33	8.73	244.44	261.90	270.63
34	8.85	247.80	265.50	274.35
35	8.97	251.16	269.10	278.07
36	9.08	254.24	272.40	281.48
37	9.20	257.60	276.00	285.20
38	9.32	260.96	279.60	288.92
39	9.43	264.04	282.90	292.33
40	9.55	267.40	286.50	296.05
41	9.67	270.76	290.10	299.77
42	9.79	274.12	293.70	303.49
43	9.90	277.20	297.00	306.90
44	10.02	280.56	300.60	310.62
45	10.14	283.92	304.20	314.34
46	10.25	287.00	307.50	317.75
47	10.37	290.36	311.10	321.47
48	10.49	293.72	314.70	325.19
49	10.60	296.80	318.00	328.60
50	10.72	300.16	321.60	332.32

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II (28)

NEW

INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR)
NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) VIII

Effective 1-1-78

The Counties included in HSA VIII are:

Kane McHenry Lake

Points	Daily Rates	Monthly Rates		
		28 Days	30 Days	31 Days
1	4.72	132.16	141.60	146.32
2	4.83	135.24	144.90	149.73
3	4.93	138.04	147.90	152.83
4	5.04	141.12	151.20	156.24
5	5.15	144.20	154.50	159.65
6	5.25	147.00	157.50	162.75
7	5.36	150.08	160.80	166.16
8	5.47	153.16	164.10	169.57
9	5.57	155.96	167.10	172.67
10	5.68	159.04	170.40	176.08
11	5.79	162.12	173.70	179.49
12	5.90	165.20	177.00	182.90
13	6.00	168.00	180.00	186.00
14	6.11	171.08	183.30	189.41
15	6.22	174.16	186.60	192.82
16	6.32	176.96	189.60	195.92
17	6.43	180.04	192.90	199.33
18	6.54	183.12	196.20	202.74
19	6.64	185.92	199.20	205.84
20	6.75	189.00	202.50	209.25
21	6.86	192.08	205.80	212.66
22	6.97	195.16	209.10	216.07
23	7.07	197.96	212.10	219.17
24	7.18	201.04	215.40	222.58
25	7.29	204.12	218.70	225.99
26	7.39	206.92	221.70	229.09
27	7.50	210.00	225.00	232.50
28	7.61	213.08	228.30	235.91
29	7.71	215.88	231.30	239.01
30	7.82	218.96	234.60	242.42
31	7.93	222.04	237.90	245.83
32	8.04	225.12	241.20	249.24
33	8.14	227.92	244.20	252.34
34	8.25	231.00	247.50	255.75
35	8.36	234.08	250.80	259.16
36	8.46	236.88	253.80	262.26
37	8.57	239.96	257.10	265.67
38	8.68	243.04	260.40	269.08
39	8.78	245.84	263.40	272.18
40	8.89	248.92	266.70	275.59
41	9.00	252.00	270.00	279.00
42	9.11	255.08	273.30	282.41
43	9.21	257.88	276.30	285.51
44	9.32	260.96	279.60	288.92
45	9.43	264.04	282.90	292.33
46	9.53	266.84	285.90	295.43
47	9.64	269.92	289.20	298.84
48	9.75	273.00	292.50	302.25
49	9.85	275.80	295.50	305.35
50	9.96	278.88	298.80	308.76

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RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II (29)

NEW

INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR)
NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) IX

Effective 1-1-78

The Counties included in HSA IX are:

Grundy Kankakee Kendall Will

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	4.45	124.60	133.50	137.95
2	4.55	127.40	136.50	141.05
3	4.64	129.92	139.20	143.84
4	4.74	132.72	142.20	146.94
5	4.84	135.52	145.20	150.04
6	4.94	138.32	148.20	153.14
7	5.04	141.12	151.20	156.24
8	5.13	143.64	153.90	159.03
9	5.23	146.44	156.90	162.13
10	5.33	149.24	159.90	165.23
11	5.43	152.04	162.90	168.33
12	5.53	154.84	165.90	171.43
13	5.62	157.36	168.60	174.22
14	5.72	160.16	171.60	177.32
15	5.82	162.96	174.60	180.42
16	5.92	165.76	177.60	183.52
17	6.02	168.56	180.60	186.62
18	6.11	171.08	183.30	189.41
19	6.21	173.88	186.30	192.51
20	6.31	176.68	189.30	195.61
21	6.41	179.48	192.30	198.71
22	6.51	182.28	195.30	201.81
23	6.60	184.80	198.00	204.60
24	6.70	187.60	201.00	207.70
25	6.80	190.40	204.00	210.80
26	6.90	193.20	207.00	213.90
27	7.00	196.00	210.00	217.00
28	7.09	198.52	212.70	219.79
29	7.19	201.32	215.70	222.89
30	7.29	204.12	218.70	225.99
31	7.39	206.92	221.70	229.09
32	7.49	209.72	224.70	232.19
33	7.58	212.24	227.40	234.98
34	7.68	215.04	230.40	238.08
35	7.78	217.84	233.40	241.18
36	7.88	220.64	236.40	244.28
37	7.98	223.44	239.40	247.38
38	8.07	225.96	242.10	250.17
39	8.17	228.76	245.10	253.27
40	8.27	231.56	248.10	256.37
41	8.37	234.36	251.10	259.47
42	8.47	237.16	254.10	262.57
43	8.56	239.68	256.80	265.36
44	8.66	242.48	259.80	268.46
45	8.76	245.28	262.80	271.56
46	8.86	248.08	265.80	274.66
47	8.96	250.88	268.80	277.76
48	9.05	253.40	271.50	280.55
49	9.15	256.20	274.50	283.65
50	9.25	259.00	277.50	286.75

RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II (30)

NEW

INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR)
NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) X

Effective 1-1-78

The Counties included in HSA X are:

Henry Mercer Rock Island

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	4.56	127.68	136.80	141.36
2	4.67	130.76	140.10	144.77
3	4.77	133.56	143.10	147.87
4	4.87	136.36	146.10	150.97
5	4.97	139.16	149.10	154.07
6	5.07	141.96	152.10	157.17
7	5.18	145.04	155.40	160.58
8	5.28	147.84	158.40	163.68
9	5.38	150.64	161.40	166.78
10	5.48	153.44	164.40	169.88
11	5.58	156.24	167.40	172.98
12	5.69	159.32	170.70	176.39
13	5.79	162.12	173.70	179.49
14	5.89	164.92	176.70	182.59
15	5.99	167.72	179.70	185.69
16	6.09	170.52	182.70	188.79
17	6.20	173.60	186.00	192.20
18	6.30	176.40	189.00	195.30
19	6.40	179.20	192.00	198.40
20	6.50	182.00	195.00	201.50
21	6.60	184.80	198.00	204.60
22	6.71	187.88	201.30	208.01
23	6.81	190.68	204.30	211.11
24	6.91	193.48	207.30	214.21
25	7.01	196.28	210.30	217.31
26	7.11	199.08	213.30	220.41
27	7.22	202.16	216.60	223.82
28	7.32	204.96	219.60	226.92
29	7.42	207.76	222.60	230.02
30	7.52	210.56	225.60	233.12
31	7.62	213.36	228.60	236.22
32	7.73	216.44	231.90	239.63
33	7.83	219.24	234.90	242.73
34	7.93	222.04	237.90	245.83
35	8.03	224.84	240.90	248.93
36	8.13	227.64	243.90	252.03
37	8.24	230.72	247.20	255.44
38	8.34	233.52	250.20	258.54
39	8.44	236.32	253.20	261.64
40	8.54	239.12	256.20	264.74
41	8.64	241.92	259.20	267.84
42	8.75	245.00	262.50	271.25
43	8.85	247.80	265.50	274.35
44	8.95	250.60	268.50	277.45
45	9.05	253.40	271.50	280.55
46	9.15	256.20	274.50	283.65
47	9.26	259.28	277.80	287.06
48	9.36	262.08	280.80	290.16
49	9.46	264.88	283.80	293.26
50	9.56	267.68	286.80	296.36

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RULE 4.14 GROUP CARE SERVICES (CONT.)
ATTACHMENT II (31)

NEW

INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR)
NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) XI

Effective 1-1-78

The Counties included in HSA XI are:

Clinton Madison Monroe St. Clair

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	4.52	126.56	135.60	140.12
2	4.62	129.36	138.60	143.22
3	4.72	132.16	141.60	146.32
4	4.82	134.96	144.60	149.42
5	4.92	137.76	147.60	152.52
6	5.03	140.84	150.90	155.93
7	5.13	143.64	153.90	159.03
8	5.23	146.44	156.90	162.13
9	5.33	149.24	159.90	165.23
10	5.43	152.04	162.90	168.33
11	5.53	154.84	165.90	171.43
12	5.63	157.64	168.90	174.53
13	5.73	160.44	171.90	177.63
14	5.83	163.24	174.90	180.73
15	5.93	166.04	177.90	183.83
16	6.04	169.12	181.20	187.24
17	6.14	171.92	184.20	190.34
18	6.24	174.72	187.20	193.44
19	6.34	177.52	190.20	196.54
20	6.44	180.32	193.20	199.64
21	6.54	183.12	196.20	202.74
22	6.64	185.92	199.20	205.84
23	6.74	188.72	202.20	208.94
24	6.84	191.52	205.20	212.04
25	6.94	194.32	208.20	215.14
26	7.05	197.40	211.50	218.55
27	7.15	200.20	214.50	221.65
28	7.25	203.00	217.50	224.75
29	7.35	205.80	220.50	227.85
30	7.45	208.60	223.50	230.95
31	7.55	211.40	226.50	234.05
32	7.65	214.20	229.50	237.15
33	7.75	217.00	232.50	240.25
34	7.85	219.80	235.50	243.35
35	7.95	222.60	238.50	246.45
36	8.06	225.68	241.80	249.86
37	8.16	228.48	244.80	252.96
38	8.26	231.28	247.80	256.06
39	8.36	234.08	250.80	259.16
40	8.46	236.88	253.80	262.26
41	8.56	239.68	256.80	265.36
42	8.66	242.48	259.80	268.46
43	8.76	245.28	262.80	271.56
44	8.86	248.08	265.80	274.66
45	8.96	250.88	268.80	277.76
46	9.07	253.96	272.10	281.17
47	9.17	256.76	275.10	284.27
48	9.27	259.56	278.10	287.37
49	9.37	262.36	281.10	290.47
50	9.47	265.16	284.10	293.57

1-1-78

SKILLED NURSING FACILITY -- PEDIATRICS (SNF-PED) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) I
Effective 1-1-78

The Counties included in HSA I are:

Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	9.24	258.72	277.20	286.44
2	9.41	263.48	282.30	291.71
3	9.59	268.52	287.70	297.29
4	9.76	273.28	292.80	302.56
5	9.93	278.04	297.90	307.83
6	10.11	283.08	303.30	313.41
7	10.28	287.84	308.40	318.68
8	10.45	292.60	313.50	323.95
9	10.62	297.36	318.60	329.22
10	10.80	302.40	324.00	334.80
11	10.97	307.16	329.10	340.07
12	11.14	311.92	334.20	345.34
13	11.32	316.96	339.60	350.92
14	11.49	321.72	344.70	356.19
15	11.66	326.48	349.80	361.46
16	11.84	331.52	355.20	367.04
17	12.01	336.28	360.30	372.31
18	12.18	341.04	365.40	377.58
19	12.35	345.80	370.50	382.85
20	12.53	350.84	375.90	388.43
21	12.70	355.60	381.00	393.70
22	12.87	360.36	386.10	398.97
23	13.05	365.40	391.50	404.55
24	13.22	370.16	396.60	409.82
25	13.39	374.92	401.70	415.09
26	13.57	379.96	407.10	420.67
27	13.74	384.72	412.20	425.94
28	13.91	389.48	417.30	431.21
29	14.03	394.24	422.40	436.48
30	14.26	399.28	427.80	442.06
31	14.43	404.04	432.90	447.33
32	14.60	408.80	438.00	452.60
33	14.73	413.84	443.40	458.13
34	14.95	418.60	448.50	463.45
35	15.12	423.36	453.60	468.72
36	15.30	428.40	459.00	474.30
37	15.47	433.16	464.10	479.57
38	15.64	437.92	469.20	484.84
39	15.81	442.68	474.30	490.11
40	15.99	447.72	479.70	495.69
41	16.16	452.48	484.80	500.96
42	16.33	457.24	490.20	506.23
43	16.51	462.28	495.30	511.81
44	16.68	467.04	500.40	517.08
45	16.85	471.80	505.50	522.35
46	17.03	476.84	510.90	527.93
47	17.20	481.60	516.00	533.20
48	17.37	486.36	521.10	538.47
49	17.54	491.12	526.20	543.74
50	17.72	496.16	531.60	549.32

(Add .173 to the daily rate for each point over 50)
(Subtract $6.85 from the daily rate for each child ages three and above).

SKILLED NURSING FACILITY -- PEDIATRICS (SNF-PED) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) II
Effective 1-1-73

The Counties included in HSA II are:

Bureau	Knox	McDonough	Stark	Woodford
Fulton	LaSalle	Peoria	Tazewell	
Henderson	Marshall	Putnam	Warren	

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	9.41	263.48	282.30	291.71
2	9.59	268.52	287.70	297.09
3	9.77	273.56	293.10	302.87
4	9.94	278.32	298.20	308.14
5	10.12	283.36	303.60	313.72
6	10.29	288.12	308.70	318.99
7	10.47	293.16	314.10	324.57
8	10.65	298.20	319.50	330.15
9	10.82	302.96	324.60	335.42
10	11.00	308.00	330.00	341.00
11	11.17	312.76	335.10	346.27
12	11.35	317.80	340.50	351.85
13	11.53	322.84	345.90	357.43
14	11.70	327.60	351.00	362.70
15	11.88	332.64	356.40	368.28
16	12.05	337.40	361.50	373.55
17	12.23	342.44	366.90	379.13
18	12.41	347.48	372.30	384.71
19	12.58	352.24	377.40	389.98
20	12.76	357.28	382.80	395.56
21	12.93	362.04	387.90	400.83
22	13.11	367.08	393.30	406.41
23	13.29	372.12	398.70	411.99
24	13.46	376.88	403.80	417.26
25	13.64	381.92	409.20	422.84
26	13.81	386.68	414.30	428.11
27	13.99	391.72	419.70	433.69
28	14.17	396.76	425.10	439.27
29	14.34	401.52	430.20	444.54
30	14.52	406.56	435.60	450.12
31	14.69	411.32	440.70	455.39
32	14.87	416.36	446.10	460.97
33	15.05	421.40	451.50	466.55
34	15.22	426.16	456.60	471.82
35	15.40	431.20	462.00	477.40
36	15.57	436.96	467.10	482.67
37	15.75	441.00	472.50	488.25
38	15.93	446.04	477.90	493.83
39	16.10	450.80	483.00	499.10
40	16.28	455.84	488.40	504.68
41	16.45	460.60	493.50	509.95
42	16.63	465.64	498.90	515.53
43	16.81	470.68	504.30	521.11
44	16.98	475.44	509.40	526.38
45	17.16	480.48	514.80	531.96
46	17.33	485.24	519.90	537.23
47	17.51	490.28	525.30	542.81
48	17.69	495.32	530.70	548.39
49	17.86	500.08	535.80	553.66
50	18.04	505.12	541.20	559.24

(Add .176 to the daily rate for each point over 50)
(Subtract $6.85 from the daily rate for each child ages three and above.)

SKILLED NURSING FACILITY -- [illegible] NURSING HOME [illegible]
HEALTH SERVICE AREA (HSA) III
Effective 1-1-83

The Counties included in HSA III are:

Adams	Christian	Logan	Montgomery	Schuyler
Brown	Greene	Macoupin	Morgan	Scott
Calhoun	Hancock	Mason	Pike	
Cass	Jersey	Menard	Sangamon	

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	9.39	262.92	281.70	291.09
2	9.56	267.68	286.80	296.36
3	9.74	272.72	292.20	301.94
4	9.91	277.48	297.30	307.21
5	10.09	282.52	302.70	312.79
6	10.26	287.28	307.80	318.06
7	10.44	292.32	313.20	323.64
8	10.61	297.08	318.30	328.91
9	10.79	302.12	323.70	334.49
10	10.96	306.88	328.80	339.76
11	11.14	311.92	334.20	345.34
12	11.31	316.68	339.30	350.61
13	11.49	321.72	344.70	356.19
14	11.66	326.48	349.80	361.46
15	11.84	331.52	355.20	367.04
16	12.01	336.28	360.30	372.31
17	12.19	341.32	365.70	377.89
18	12.36	346.08	370.80	383.16
19	12.54	351.12	376.20	388.74
20	12.71	355.88	381.30	394.01
21	12.89	360.92	386.70	399.59
22	13.06	365.68	391.80	404.86
23	13.24	370.72	397.20	410.44
24	13.41	375.48	402.30	415.71
25	13.59	380.52	407.70	421.29
26	13.76	385.28	412.80	426.56
27	13.94	390.32	418.20	432.14
28	14.11	395.08	423.30	437.41
29	14.29	400.12	428.70	442.99
30	14.46	404.88	433.80	448.26
31	14.64	409.92	439.20	453.84
32	14.81	414.68	444.30	459.11
33	14.99	419.72	449.70	464.69
34	15.16	424.48	454.80	469.96
35	15.34	429.52	460.20	475.54
36	15.51	434.28	465.30	480.81
37	15.69	439.32	470.70	486.39
38	15.86	444.08	475.80	491.66
39	16.04	449.12	481.20	497.24
40	16.21	453.88	486.30	502.51
41	16.39	458.92	491.70	508.09
42	16.56	463.68	496.80	513.36
43	16.74	468.72	502.20	518.94
44	16.91	473.48	507.30	524.21
45	17.09	478.52	512.70	529.79
46	17.26	483.28	517.80	535.06
47	17.44	488.32	523.20	540.64
48	17.61	493.08	528.30	545.91
49	17.79	498.12	533.70	551.49
50	17.96	502.88	538.80	556.76

(Add .203 to the daily rate for each point over 50)
(Subtract $6.85 from the daily rate for each child ages three and above).

SKILLED NURSING FACILITY -- PEDIATRICS (SNF-PED) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) IV Effective 1-1-83

The Counties included in HSA IV are:

Champaign	DeWitt	Ford	Macon	Piatt
Clark	Douglas	Iroquois	McLean	Shelby
Coles	Edgar	Livingston	Moultrie	Vermilion
Cumberland				

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	9.41	263.48	282.30	291.71
2	9.59	268.52	287.70	297.29
3	9.77	273.56	293.10	302.87
4	9.94	278.32	298.20	308.14
5	10.12	283.36	303.60	313.72
6	10.29	288.12	308.70	318.99
7	10.47	293.16	314.10	324.57
8	10.65	298.20	319.50	330.15
9	10.82	302.96	324.60	335.42
10	11.00	308.00	330.00	341.00
11	11.17	312.76	335.10	346.27
12	11.35	317.80	340.50	351.85
13	11.53	322.84	345.90	357.43
14	11.70	327.60	351.00	362.70
15	11.88	332.64	356.40	368.28
16	12.05	337.40	361.50	373.55
17	12.23	342.44	366.90	379.13
18	12.41	347.48	372.30	384.71
19	12.58	352.24	377.40	389.98
20	12.76	357.28	382.80	395.56
21	12.93	362.04	387.90	400.83
22	13.11	367.08	393.30	406.41
23	13.29	372.12	398.70	411.99
24	13.46	376.88	403.80	417.26
25	13.64	381.92	409.20	422.84
26	13.81	386.68	414.30	428.11
27	13.99	391.72	419.70	433.69
28	14.17	396.76	425.10	439.27
29	14.34	401.52	430.20	444.54
30	14.52	406.56	435.60	450.12
31	14.69	411.32	440.70	455.39
32	14.87	416.36	446.10	460.97
33	15.05	421.40	451.50	466.55
34	15.22	426.16	456.60	471.82
35	15.40	431.20	462.00	477.40
36	15.57	436.96	467.10	482.67
37	15.75	441.00	472.50	488.25
38	15.93	446.04	477.90	493.83
39	16.10	450.80	483.00	499.10
40	16.28	455.84	488.40	504.68
41	16.45	460.60	493.50	509.95
42	16.63	465.64	498.90	515.53
43	16.81	470.68	504.30	521.11
44	16.98	475.44	509.40	526.38
45	17.16	480.48	514.80	531.96
46	17.33	485.24	519.90	537.23
47	17.51	490.28	525.30	542.81
48	17.69	495.32	530.70	548.39
49	17.86	500.08	535.80	553.66
50	18.04	505.12	541.20	559.24

(Add .176 to the daily rate for each point over 50)
(Subtract $6.85 from the daily rate for each child ages three and above.)

SKILLED NURSING FACILITY -- PROJECTED (CRAFTED) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) V Effective 1-1-83

The Counties included in HSA V are:

Alexander	Edwards	Gallatin	Jasper	Marion	Pulaski	Union	White
Bond	Effingham	Hamilton	Jefferson	Massac	Randolph	Wabash	Williamson
Clay	Fayette	Hardin	Johnson	Perry	Richland	Washington	
Crawford	Franklin	Jackson	Lawrence	Pope	Saline	Wayne	

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	9.19	257.32	275.70	284.89
2	9.37	262.36	281.10	290.47
3	9.54	267.12	286.20	295.74
4	9.71	271.88	291.30	301.01
5	9.83	275.24	294.90	304.73
6	10.05	281.40	301.50	311.55
7	10.23	286.44	306.90	317.13
8	10.40	291.20	312.00	322.40
9	10.57	295.96	317.10	327.67
10	10.74	300.72	322.20	332.94
11	10.91	305.48	327.30	338.21
12	11.09	310.52	332.70	343.79
13	11.26	315.28	337.80	349.06
14	11.43	320.04	342.90	354.33
15	11.60	324.80	348.00	359.60
16	11.77	329.56	353.10	364.87
17	11.95	334.60	358.50	370.45
18	12.12	339.36	363.60	375.72
19	12.29	344.12	368.70	380.99
20	12.46	348.88	373.80	386.26
21	12.63	353.64	378.90	391.53
22	12.81	358.68	384.30	397.11
23	12.98	363.44	389.40	402.38
24	13.15	368.20	394.50	407.65
25	13.32	372.96	399.60	412.92
26	13.49	377.72	404.70	418.19
27	13.67	382.76	410.10	423.77
28	13.84	387.52	415.20	429.04
29	14.01	392.28	420.30	434.31
30	14.18	397.04	425.40	439.58
31	14.35	401.80	430.50	444.85
32	14.53	406.84	435.90	450.43
33	14.70	411.60	441.00	455.70
34	14.87	416.36	446.10	460.97
35	15.04	421.12	451.20	466.24
36	15.21	425.88	456.30	471.51
37	15.39	430.92	461.70	477.09
38	15.56	435.68	466.80	482.36
39	15.73	440.44	471.90	487.63
40	15.90	445.20	477.00	492.90
41	16.07	449.96	482.10	498.17
42	16.25	455.00	487.50	503.75
43	16.42	459.76	492.60	509.02
44	16.59	464.52	497.70	514.29
45	16.76	469.28	502.80	519.56
46	16.93	474.04	507.90	524.83
47	17.11	479.08	513.30	530.41
48	17.28	483.84	518.40	535.68
49	17.45	488.60	523.50	540.95
50	17.62	493.36	528.60	546.22

(Add .172 to the daily rate for each point over 50)
(Subtract $6.85 from the daily rate for each child ages three and above.)

SKILLED NURSING FACILITY -- PEDIATRICS (SNF-PED) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) VI & VII
Effective 1-1-93

The Counties included in HSAs VI & VII are:

Cook and DuPage

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	11.00	308.00	330.00	341.00
2	11.20	313.60	336.00	347.20
3	11.41	319.48	342.30	353.71
4	11.61	325.08	348.30	359.91
5	11.82	330.96	354.60	366.42
6	12.03	336.84	360.90	372.93
7	12.23	342.44	366.90	379.13
8	12.44	348.32	373.20	385.64
9	12.64	353.92	379.20	391.84
10	12.85	359.80	385.50	398.35
11	13.06	365.68	391.80	404.86
12	13.26	371.28	397.80	411.06
13	13.47	377.16	404.10	417.57
14	13.67	382.76	410.10	423.77
15	13.83	387.24	416.40	430.28
16	14.09	394.52	422.70	436.79
17	14.29	400.12	428.70	442.99
18	14.50	406.00	435.00	449.50
19	14.70	411.60	441.00	455.70
20	14.91	417.48	447.30	462.21
21	15.12	423.36	453.60	468.72
22	15.32	428.96	459.60	474.92
23	15.53	434.84	465.90	481.43
24	15.73	440.44	471.90	487.63
25	15.94	446.32	478.20	494.14
26	16.15	452.20	484.50	500.65
27	16.35	457.80	490.50	506.85
28	16.56	463.68	496.80	513.36
29	16.76	469.28	502.80	519.56
30	16.97	475.16	509.10	526.07
31	17.18	481.04	515.40	532.58
32	17.38	486.64	521.40	538.78
33	17.59	492.52	527.70	545.29
34	17.79	498.12	533.70	551.49
35	18.00	504.00	540.00	558.00
36	18.21	509.88	546.30	564.51
37	18.41	515.48	552.30	570.71
38	18.62	521.36	558.60	577.22
39	18.82	526.96	564.60	583.42
40	19.03	532.84	570.90	589.93
41	19.24	538.72	577.20	596.44
42	19.44	544.32	583.20	602.64
43	19.65	550.20	589.50	609.15
44	19.85	555.80	595.50	615.35
45	20.06	561.68	601.80	621.86
46	20.27	567.56	608.10	628.37
47	20.47	573.16	614.10	634.57
48	20.68	579.04	620.40	641.08
49	20.88	584.64	626.40	647.28
50	21.09	590.52	632.70	653.79

(Add .206 to the daily rate for each point over 50)
(Subract $6.85 from the daily rate for each child ages three and above.)

SKILLED NURSING FACILITY -- PEDIATRICS (SNF-PED) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) VIII Effective 1-1-93

The Counties included in HSA VIII are:

Kane McHenry Lake

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	10.12	283.36	303.60	313.72
2	10.31	288.68	309.30	319.61
3	10.50	294.00	315.00	325.50
4	10.69	299.32	320.70	331.39
5	10.88	304.64	326.40	337.28
6	11.07	309.96	332.10	343.17
7	11.26	315.28	337.80	349.06
8	11.45	320.60	343.50	354.95
9	11.64	325.92	349.20	360.84
10	11.83	331.24	354.90	366.73
11	12.01	336.28	360.30	372.31
12	12.20	341.60	366.00	378.20
13	12.39	346.92	371.70	384.09
14	12.58	352.24	377.40	389.98
15	12.77	357.56	383.10	395.87
16	12.96	362.88	388.80	401.76
17	13.15	368.20	394.50	407.65
18	13.34	373.52	400.20	413.54
19	13.53	378.84	405.90	419.43
20	13.72	384.16	411.60	425.32
21	13.90	389.20	417.00	430.80
22	14.09	394.52	422.70	436.69
23	14.28	399.84	428.40	442.58
24	14.47	405.16	434.10	448.47
25	14.66	410.48	439.80	454.36
26	14.85	415.80	445.50	460.25
27	15.04	421.12	451.20	466.14
28	15.23	426.44	456.90	472.03
29	15.42	431.76	462.60	477.92
30	15.61	437.08	468.30	483.81
31	15.79	442.12	473.70	489.39
32	15.98	447.44	479.40	495.28
33	16.17	452.76	485.10	501.27
34	16.36	458.08	490.80	507.16
35	16.55	463.40	496.50	513.05
36	16.74	468.72	502.20	518.94
37	16.93	474.04	507.90	524.83
38	17.12	479.36	513.60	530.72
39	17.31	484.68	519.30	536.61
40	17.50	490.00	525.00	542.50
41	17.69	495.32	530.40	548.08
42	17.87	500.36	536.10	553.97
43	18.06	505.68	541.80	559.86
44	18.25	511.00	547.50	565.75
45	18.44	516.32	553.20	571.64
46	18.63	521.64	558.90	577.53
47	18.82	526.96	564.60	583.42
48	19.01	532.28	570.30	589.31
49	19.20	537.60	576.00	595.20
50	19.39	542.92	581.70	601.09

(Add .190 to the daily rate for each point over 50)
(Subtract $6.85 from the daily rate for each child ages three and above.)

SKILLED NURSING FACILITY -- PEDIATRICS (SNF-PED) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) IX
Effective 1-1-73

The Counties included in HSA IX are:

Grundy Kankakee Kendall Will

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	9.29	260.12	278.70	287.99
2	9.46	264.88	283.80	293.26
3	9.63	269.64	288.90	298.53
4	9.81	274.68	294.30	304.11
5	9.93	278.04	298.40	308.38
6	10.15	284.20	304.50	314.65
7	10.32	288.96	309.60	319.92
8	10.50	294.00	315.00	325.50
9	10.67	298.76	320.10	330.77
10	10.84	303.52	325.20	336.04
11	11.02	308.56	330.60	341.62
12	11.19	313.32	335.70	346.89
13	11.36	318.08	340.80	352.16
14	11.54	323.12	346.20	357.74
15	11.71	327.88	351.30	363.01
16	11.88	332.64	356.40	368.28
17	12.05	337.40	361.50	373.55
18	12.23	342.44	366.90	379.13
19	12.40	347.20	372.00	384.40
20	12.57	351.96	377.10	389.67
21	12.75	357.00	382.50	395.25
22	12.92	361.76	387.60	400.52
23	13.09	366.52	392.70	405.79
24	13.27	371.56	398.10	411.37
25	13.44	376.32	403.20	416.64
26	13.61	381.08	408.30	421.91
27	13.73	384.44	411.90	425.63
28	13.96	390.88	418.80	432.76
29	14.13	395.64	423.90	438.03
30	14.30	400.40	429.00	443.30
31	14.48	405.44	434.40	448.88
32	14.65	410.20	439.50	454.15
33	14.82	414.96	444.60	459.42
34	15.00	420.00	450.00	465.00
35	15.17	424.76	455.10	470.27
36	15.34	429.52	460.20	475.54
37	15.51	434.28	465.30	480.81
38	15.69	439.32	470.70	486.39
39	15.86	444.08	475.80	491.66
40	16.03	448.84	480.90	496.93
41	16.21	453.88	486.30	502.51
42	16.38	458.64	491.40	507.78
43	16.55	463.40	496.50	513.05
44	16.73	468.44	501.90	518.63
45	16.90	473.20	507.00	523.90
46	17.07	477.96	512.10	529.17
47	17.24	482.72	517.20	534.44
48	17.42	487.76	522.60	540.02
49	17.59	492.52	527.70	545.29
50	17.76	497.28	532.80	550.56

(Add .174 to the daily rate for each point over 50)

(Subtract $6.35 from the daily rate for each child ages three and above.)

SKILLED NURSING FACILITY -- PEDIATRICS (SNF-PED) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) X
Effective 1-1-73

The Counties included in HSA X are:

Henry Mercer Rock Island

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	9.64	269.92	289.20	293.84
2	9.82	274.96	294.60	304.42
3	10.00	280.00	300.00	310.00
4	10.18	285.04	305.40	315.58
5	10.36	290.08	310.80	321.16
6	10.54	295.12	316.20	326.74
7	10.72	300.16	321.60	332.32
8	10.90	305.20	327.00	337.90
9	11.08	310.24	332.40	343.48
10	11.26	315.28	337.80	349.06
11	11.44	320.32	343.20	354.64
12	11.62	325.36	348.60	360.22
13	11.80	330.40	354.00	365.80
14	11.98	335.44	359.40	371.38
15	12.16	340.48	364.80	376.96
16	12.34	345.52	370.20	382.54
17	12.52	350.56	375.60	388.12
18	12.78	355.60	381.00	393.70
19	12.88	360.64	386.40	399.28
20	13.06	365.68	391.80	404.86
21	13.24	370.72	397.20	410.44
22	13.42	375.76	402.60	416.02
23	13.60	380.80	408.00	421.60
24	13.78	385.84	413.40	427.18
25	13.96	390.88	418.80	432.76
26	14.14	395.92	424.20	438.34
27	14.32	400.96	429.60	443.92
28	14.50	406.00	435.00	449.50
29	14.68	411.04	440.40	455.08
30	14.86	416.08	445.80	460.66
31	15.04	421.12	451.20	466.24
32	15.22	426.16	456.60	471.82
33	15.40	431.20	462.00	477.40
34	15.58	436.24	467.40	482.98
35	15.76	441.28	472.80	488.56
36	15.94	446.32	478.20	494.14
37	16.12	451.36	483.60	499.72
38	16.30	456.40	489.00	505.30
39	16.48	461.44	494.40	510.88
40	16.66	466.48	499.80	516.46
41	16.84	471.52	505.20	522.04
42	17.02	476.56	510.60	527.62
43	17.20	481.60	516.00	533.20
44	17.38	486.64	521.40	538.78
45	17.56	491.68	526.80	544.36
46	17.74	496.72	532.20	549.94
47	17.92	501.76	537.60	555.52
48	18.10	506.80	543.00	561.10
49	18.28	511.84	548.40	566.68
50	18.46	516.88	553.80	572.26

PR-1115.6

(Add .181 to the daily rate for each point over 50)
(Subtract $6.85 from the daily rate for each child ages three and above).

SKILLED NURSING FACILITY -- PEDIATRICS (SNF-PED) NURSING COSTS BY POINT COUNT
HEALTH SERVICE AREA (HSA) XI
Effective 1-1-73

The Counties included in HSA XI are:

Clinton Madison Monroe St. Clair

Points	Daily Rates	Monthly Rates 28 Days	30 Days	31 Days
1	9.98	279.44	299.40	309.38
2	10.16	284.48	304.80	314.96
3	10.35	289.80	310.50	320.85
4	10.54	295.12	316.20	326.74
5	10.72	300.16	321.60	332.32
6	10.91	305.48	327.30	338.21
7	11.09	310.52	332.70	343.79
8	11.28	315.84	338.40	349.68
9	11.47	321.16	344.10	355.57
10	11.65	326.20	349.50	361.15
11	11.84	331.52	355.20	367.04
12	12.02	336.56	360.60	372.62
13	12.21	341.88	366.30	378.51
14	12.40	347.20	372.00	384.40
15	12.58	352.24	377.40	389.98
16	12.77	357.56	383.10	395.87
17	12.95	362.60	388.50	401.45
18	13.14	367.92	394.20	407.34
19	13.33	373.24	399.90	413.23
20	13.51	378.28	405.30	418.81
21	13.70	383.60	411.00	424.70
22	13.88	388.64	416.40	430.28
23	14.07	393.96	422.10	436.17
24	14.26	399.28	427.80	442.06
25	14.44	404.32	433.20	447.64
26	14.63	409.64	438.90	453.53
27	14.81	414.68	444.30	459.11
28	15.00	420.00	450.00	465.00
29	15.19	425.32	455.70	470.89
30	15.37	430.36	461.10	476.47
31	15.56	435.68	466.80	482.36
32	15.74	440.72	472.20	487.94
33	15.93	446.04	477.90	493.83
34	16.12	451.36	483.60	499.72
35	16.30	456.40	489.00	505.30
36	16.49	461.72	494.70	511.19
37	16.67	466.76	500.10	516.77
38	16.86	472.08	505.80	522.66
39	17.05	477.40	511.50	528.55
40	17.23	482.44	516.90	534.13
41	17.42	487.76	522.60	540.02
42	17.60	492.80	528.00	545.60
43	17.79	498.12	533.70	551.49
44	17.98	503.44	539.40	557.38
45	18.16	508.48	544.80	562.96
46	18.35	513.80	550.50	568.85
47	18.53	518.84	556.00	574.43
48	18.72	524.16	561.60	580.32
49	18.91	529.48	567.30	586.21
50	19.09	534.52	572.70	591.79

(Add .187 to the daily rate for each point over 50)
(Subtract $6.85 from the daily rate for each child ages three and above.)

RULE 4.14 GROUP CARE SERVICES (CONT.)

ATTACHMENT III

CUMULATIVE INDEX issue - page

PROPOSED RULES

(continued)

CUMULATIVE INDEX issue - page

PROPOSED RULES - Continued

(continued)

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PROPOSED RULES - Continued

(continued)

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EMERGENCY RULES - Continued

(continued)

CUMULATIVE INDEX issue - page

ALAN J. DIXON
Secretary of State

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